

Healing Waters Cleansing Center-Colon Hydrotherapy
15578 Middlebelt Road • Livonia, Michigan • 48154
P. 734.751.7674 • F. 248.888.0054

CONFIDENTIAL HISTORY

Name: _____

Home Phone: _____

Address: _____

Alt. Phone: _____

City: _____ State _____ Zip _____

Date of Birth: ____/____/____

Email: _____

Occupation: _____

How did you hear about us?

Internet Personal Reference Other

Please Explain: _____

Why have you chosen to have a Colonic/Colon Hydrotherapy Session?

Under a Medical Providers Care? By Prescription? 9th Amendment Right?

Medical Providers Name: _____

How many bowel movements per week? _____

In Pain? _____ Where? _____

Do you use laxatives? _____

What Kind? _____

Please list any medications or over-the-counter medications you are taking and for what ailment(s):

Please list any surgical procedures along with the date performed and for what reason:

Contraindications: Please check and date if the following apply to you:

____ Abdominal Hernia
____ Abdominal Surgery
____ Abnormal Distension
____ Acute Liver Failure
____ Anemia
____ Aneurysm-All Types
____ Cancer of the Colon
____ Cardiac Condition
____ Crohns Disease
____ Colitis
____ Hepatitis B or C

____ Diverticulosis/Diverticulitis
____ Fissures & Fistulas
____ Hemorrhaging
____ Hemorrhoidectomy
____ Intestinal Perforations
____ Lupus
____ Pregnant? Due Date _____
____ Rectal/Colon Surgery
____ Renal Insufficiencies
____ Irritable Bowel Syndrome
____ AIDS

____ Bladder Infections
____ Bloating
____ Blood in Stool
____ BM Difficult
____ Itching Anus
____ Constipation
____ Diarrhea
____ Infectious Disease
____ Hemorrhoids
____ Colonoscopy
____ Rectal Bleeding

Is there a history of colon cancer in your family YES NO

Any other considerations we should be aware of? _____

Have you experienced Colon Hydrotherapy before? YES NO Where? When _____

Do you participate in any other forms of alternative healing? _____

Do you exercise?

Are you on a special diet?

How frequently do you consume the following (per week): Red Meat_____Poultry_____Fish_____ Dairy_____White Bread_____Fruits_____Vegetables_____Soda/Pop_____Natural Juicing_____ Grains_____Alcohol_____Coffee_____Cigarettes_____Fast Foods_____

How many glasses of water do you drink daily?_____

FULL DISCLOSURE

I UNDERSTAND AND FULLY DISCLOSE ANY AND ALL MEDICAL TREATMENTS THAT I HAVE HAD IN THE PAST ONE (5) YEARS THAT MAY DIRECTLY OR INDIRECTLY BE RELATED TO ME PARTICIPATING IN THE USE OF COLON HYDROTHERAPY. THIS MAY INCLUDE BUT IS NOT LIMITED TO GASTROINTESTINAL EVALUATIONS, DIAGNOSIS, PROCEDURES, MEDICATIONS, SURGERIES AND THE LIKE. ALSO, BUT NOT LIMITED TO ANY PROCTOLOGY DIAGNOSIS, EVALUATIONS, PROCEDURE, MEDICATIONS AND SURGERIES. BY SIGNING THIS FORM, I AM DISCLOSING THAT I HAVE NOT HAD ANY UNDISCLOSED GASTROINTESTINAL PROCEDURES SUCH AS; BUT NOT LIMITED TO EGD (ESOPHAGEAL STOMACH SCOPE), COLONOSCOPY, SIGMOIDOSCOPY, ANAL SCOPE AND THE LIKE. I HEREBY CONSENT TO THE SERVICES THAT WILL BE PROVIDED AS WELL AS MY OWN PHYSICAL LIMITATIONS AND I AGREE TO ASSUME THE RISK OF ACCEPTING THIS SERVICE. I ACKNOWLEDGE IF I HAVE ANY MEDICAL CONDITIONS THAT MAY BE AFFECTED BY THE SERVICE REQUESTED, I WILL ADVISE AND DISCUSS SUCH CONDITIONS WITH THE SERVICE PROVIDER. I AM AWARE THAT IT IS ALWAYS ADVISABLE TO CONSULT A PHYSICIAN BEFORE UNDERTAKING ANY SUCH SERVICE.

I HAVE NOT BEEN DIAGNOSED WITH ANY CONTRAINDICATIONS FOR COLON HYDROTHERAPY. I AM AWARE THAT COLON HYDROTHERAPISTS ARE NOT PHYSICIANS AND THEREFORE DO NOT INSERT, DIAGNOSE OR PRESCRIBE. I AM AWARE THAT ADVERSE EVENTS SUCH AS PERFORATION, INJURY AND ILLNESS HAVE BEEN ALLEGED AND CLAIMED WITH THE USE OF COLON HYDROTHERAPY AND ENEMA DEVICES. ***I AM RESPONSIBLE FOR MY OWN SELF-INSERTION.*** IF I EXPERIENCE RESISTANCE DURING THE INSERTION, I WILL IMMEDIATELY STOP MY SESSION. IF DURING THE SESSION I EXPERIENCE DISCOMFORT OR PAIN, I AM RESPONSIBLE FOR IMMEDIATELY STOPPING MY SESSION. I AM AWARE THIS FACILITY DOES NOT CLAIM TO CURE OR TREAT ANY CONDITION OR DISEASE.

I FULLY UNDERSTAND AND ACCEPT ANY AND ALL LIABILITY IF THESE ARE NOT DISCLOSED IN WRITING AND PLACED IN MY FILE. I FURTHER RELEASE HEALING WATERS CLEANSING CENTER, INC. FROM ALL HARM REGARDING THESE ISSUES AS STATED ABOVE.

Client Signature: _____ Date: _____
(For clients 18 or under, the signature and attendance of the parent or guardian for insertion is required)

I have reviewed this form with my client.

Therapist Signature: _____ Date: _____

MAY WE CONTACT YOU VIA EMAIL OR VIA HOME ADDRESS WHEN OFFERS BECOME AVAILABLE? YES _____ NO _____