Alist Wellness Center LLC
www.alistwellnesscenter.com / Email: tsila@alistwellnesscenter.com / office 973-912-4448

Colon Hydrotherapy Health History
All information is kept strictly confidential

Last Name: ______________________________ First Name: ______________________________

Reason for Visit: ____Date: ____________

Please indicate if you are having any current problems signs or symptoms
Please put an (Yes) beside that is currently a problem. Put (No) beside a past problem:

Arthritis	Do you smoke	Recent Barium enema	Ulcers
Alcoholism	Digestive Problems	Migraine Headaches	Skin Problems
Blood Clots	Infectious Diseases	BM painful/difficult	Sinus Problems
Blood in Stool	Diabetics	Rectal Bleeding	Spinal Injuries
Circulatory Problems	IBS	Parasites	Respiratory Problems
Contact Lenses wear	Bladder infection	Muscle Pains	Tumors
Constipation	Burning /Itching Anus	Joint Pain	High blood pressure
Cholesterol	Recent Colonoscopy	Pregnant/woman	Tumors

Name______________________________________Signature______________________Date_______

Additional health history for Colon Hydrotherapy
The following are Contraindications for Colon Hydrotherapy
If any of these apply to you, we are not able to treat you with Colon Hydrotherapy at the present time
Please put an (Yes) beside that is currently a problem. Put (No) beside a past problem:

Abdominal Hernia	Carcinoma of the colon / rectum	Fissures Fistulas
Abdominal Surgery	Cancer	Hemorrhaging
Abdominal Distention	Cirrhosis of the Liver	GI hemorrhage /
Acute Liver Failure	Congestive Heart Failure	Renal Insufficiency
Anemia - Severe	Colon and Rectal Surgery	Diverticulitis inflammation
Aneurysm All Types	Colitis	Intestinal Perforation
Advanced Pregnancy	Crohns Disease	Severe Hemorrhoids
Colitis	Dialysis	Uncontrolled Hypertension

I have never been diagnosed with any contraindications for colon irrigation (see above list). I am aware that Colon Hydrotherapist is not a Physician and therefore does not diagnose or prescribe. I am aware adverse events such as perforation, injury and illness have been alleging and claimed with the use of colon irrigation and enema devices. If during the session I experience discomfort or pain, I am responsible for immediately stopping my session. This facility does not claim or cure or treat any condition or disease.

I prefer to insert my own speculum ____ I prefer to allow my Colon Hydrotherapist to insert my speculum____

Date__________Name______________________________Signature______________________________

(For clients 18 years of age under, the signature attendance of the parents of guardian for insertion is required)

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Colon Hydrotherapy

In order to serve you properly, we will need the following information. (Please print)

Last name ________________________First name____________________ M ____ F____ Date Birth__________________

Address _______________________________________City ________________________ State ___________ Zip_______

Home phone ____________________Cell phone: ____________________ Email: ______________________________

Employer____________________________ Your occupation: ______________________Work phone: ________________

Your Height ________________Weight____________ Exercise (type and frequency) ____________________________

EMERGENCY CONTACT INFORMATION

Name of person ____________________________Relationship ____________________Cell Phone: _________________

Address ____City _______________________Zip____________

CLIENT REFERRAL INFORMATION

Referred by ___________________________ If referred by a friend, may we thank her or him? Yes________ No_______

Doctor _________Website ______ Search engine _______ Google_______ Yahoo _______ Other ________FB_______

Are you currently under doctor's care of a Medical Doctor or other Alternative Health Care Provider? Y_______N______

Describe your major complaint_______________________________ Other complaints_____________________________

How long you have had this condition ____

List any medical conditions for which you are currently being treated or have been treated for within last five years

____

Please list any medications that you are currently taking ____

Please list any supplements that you are currently taking ____

Type Illness, Injury or Surgery____

Do you have any allergies? (Include foods & medications) ____

Please list any information about your health in which you feel we should know: _________________________________

Have you ever had colon hydrotherapy session? Yes____ No____ Type of system used? Open ____closed____ If yes, when, and how many, and the reason you chose colon hydrotherapy______________________

Bowel movements frequency less than once a week ___once a week___ every ___days daily ___twice daily___ other___

Occurrence Spontaneous_____ Only after eating ______ Effortless______ often requires straining _____ painful_______

Laxative use frequent _____occasional _____never _____other _____type of laxative______________________________

Name____Signature_______________________________Date___________

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I, ____, herby authorize / consent to allow Certified Practitioners of Alist Wellness Center LLC, to perform alternative therapies. The therapies offered to me are Colon Hydrotherapy. Colon Hydrotherapy is not intended to replace the relationship with your primary health care providers and my consultation is not intended as a Colon Hydrotherapist is not medical advice. They are intended as a sharing of knowledge and information from my education, research, training, and experience. As a Colon Hydrotherapist, I encourage you to be open to new information on the effectiveness of Colon Hydrotherapy and the fundamental role of diet, exercise, supplementation, stress management and emotional and mental work. I encourage you to make your own health decisions based upon your research and in partnership with your primary health care providers, ND, MD or otherwise.
The procedure has been explained and all my questions have been answered before the session, and I agree to participate.
I have read this entire document which is provided in a language I can read and completely understand.
My signature below indicates this as true.

______________________________ Print client's name	______________________________ Client's email
______________________________ Client's signature	______________________________ Today's date
______________________________ Therapist Name	______________________________ Today's date
______________________________ Therapist signature	______________________________ Today's date

Please follow the instructions of the Therapist. You must be always draped/covered.
This facility does not claim to cure or treat any condition or disease