

Full Circle Health Clinic

Colon Hydrotherapy History

Please PRINT and answer all questions:

Date: _____

Name: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ How Long?: _____

Why have you chosen to have Colon Hydrotherapy session(s)? Please check (✓) all that apply:

Friend _____ Phone Book _____ TV _____ Brochure _____ Sign _____ Desire Better Colon Hygiene _____
Doctor _____

How did you hear about us? _____

Reason for visit _____

***Contraindications: (✓) and Date if ever had any of the following:**

DATE:

_____ Abdominal Hernia
_____ Abdominal Surgery
_____ Abdominal Distention
_____ Acute Liver Failure
_____ Anemia
_____ Aneurysm- All Types
_____ Cancer-Type _____
_____ Cardiac Condition
_____ Crohns Disease
_____ Colitis

DATE:

_____ Dialysis Patient
_____ Diverticulosis/Diverticulitis
_____ Fissures & Fistulas
_____ Hemorrhaging
_____ Hemorrhoidectomy
_____ Intestinal Perforations
_____ Pregnant (due date) _____
_____ Rectal/Colon Surgery
_____ Renal Insufficiencies
_____ Lupus

Please Check (✓)

_____ Hemorrhoids
_____ Internal ___ External
_____ Rectal/Blood in Stool
_____ Recent Colonoscopy
_____ Use Laxatives
_____ BM Painful/Difficult
_____ Burning/Itching Anus
_____ Constipation/ Diarrhea
_____ Vomiting ___ Bloating
_____ High Blood Pressure
_____ Infectious Disease
_____ Date of Last Menstrual
_____ Allergic to Latex
_____ Bladder Infection
Other _____

I have not been diagnosed with any contraindications for colon therapy: client initials X _____

How often do you have Bowel Movements? _____

Are you under a Doctor's care? _____

Explain: _____

Any medications: _____

*Additional Health Notes

*I acknowledge if I choose not to follow the colon hydrotherapist's directions and allow the device to run dry, I will be liable for a \$75 charge to replace the damaged filer.

Please Initial:

X _____

PREPAID DISCOUNTED SESSION PACKAGES SOLD AS FOLLOWS:

All prepaid discounted colonic sessions are to be used within six (6) months of purchase
No shows or cancellations without a 12 hour advance will result in a \$25 fee

Client Signature: X _____

Therapist Notes of Client Needs:

Flex Cut ___ normal or needs ____ inches

Likes _____ session room.

Other: _____