Complete the following for Hydrocolonic Therapy

Why have you chosen to have a colonic session?

Doctor suggestion: ☐ Right to Self Treat: ☐ Other: _____

Please indicate any of the following which you have been diagnosed, have currently or experienced:

- ☐ Abdominal Hernia
- ☐ Dialysis
- ☐ Abdominal Surgery
- ☐ Diverticulosis/Diverticulitis
- ☐ Abdominal Distention
- ☐ Rectal Fissures & Fistulas
- ☐ Acute Liver Failure
- ☐ Hemorrhaging
- ☐ Are you currently taking any medications which may weaken the intestinal wall?
- ☐ Severe Anemias
- ☐ Hemorrhoidectomy
- ☐ Aneurysm – All Types
- ☐ Intestinal Perforations
- ☐ Carcinoma of the Colon
- ☐ Lupus
- ☐ Crohn's Disease
- ☐ Rectal/ Colon Surgery
- ☐ Renal Insufficiencies
- ☐ Colitis
- ☐ Jaundice
- ☐ Heart Trouble
- ☐ Rectal Bleeding
- ☐ Currently Pregnant/Date of last menstrual cycle? _____
- ☐ Severe Cardiac Disease
- ☐ Cirrhosis

Do you now have or have you recently (within the last year) experienced any of the following:

- ☐ Painful Bowel Movement
- ☐ Bladder Infection
- ☐ Blood in Stool
- ☐ Burning/ Itching Anus
- ☐ High Blood Pressure
- ☐ Hemorrhoids
- ☐ Barium Enema
- ☐ Colonoscopy
- ☐ Vomiting

General Health Information:

- ☐ Acne
- ☐ Allergies
- ☐ Belching/ Gas
- ☐ Boils
- ☐ Chronic Cough
- ☐ Difficult Breathing
- ☐ Dry Skin
- ☐ Joint Pain
- ☐ Itching
- ☐ Rashes
- ☐ Sweating
- ☐ Fever
- ☐ Chills
- ☐ Nausea
- ☐ Fainting
- ☐ Nervousness
- ☐ Excessive Hunger
- ☐ Bruises Easily
- ☐ Chest Pain
- ☐ Pain in Abdomen
- ☐ Constipation
- ☐ Overweight
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Kidney Problems
- ☐ Liver Trouble
- ☐ Parasites
- ☐ Headaches
- ☐ Depression
- ☐ Insomnia
- ☐ Fatigue
- ☐ Diarrhea

☐ Have you ever been diagnosed with an infectious disease? (HIV/ AIDS, Hepatitis A, B, or C, etc.)

Explain: _____

Are you currently taking laxatives? Yes ☐ **No** ☐ How often? _____ (times per week)

Have you had professional hydrocolon therapy recently (within the last year)? Yes ☐ **No** ☐

If so, where and when? _____

What is your primary health goal or concern at this time? _____

_____

Hydrocolonic Therapy Acknowledgement

I have discussed all indicated contraindications on this form, if any, with the therapist as it relates to the use of colon hydrotherapy. I am aware that hydrocolonic therapists are not physicians and cannot diagnose, treat, prescribe or perform any invasive procedures. If during a session I experience any discomfort or pain, I am responsible for immediately stopping the session and notifying the therapist. I acknowledge BEAUTY EQUALS HEALTH makes no claim for hydrocolon therapy as a cure or treatment for any medical condition or disease. I understand hydrocolon therapy is not a substitute for medical treatment.

Informed Consent

I, the undersigned, agree that hydrocolon therapy and/or colon irrigation is not a proven method, cure, or treatment of any disease, condition or illness, nor has it been portrayed to me as such.

If you are currently taking any medication for any condition, either prescription or non-prescription or if you have ever been diagnosed with any intestinal condition or have taken any medication that can weaken the intestinal walls you should consult a physician before using colonic irrigation. If you are not sure of the side effects of any drugs you are using, you should consult a licensed health care provider.

But my signature below, I attest that all contraindications/adverse conditions have been fully explained and discussed with me. I certify that none of contraindications/adverse conditions applies to me. I certify and affirm that I have listed all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I fail to do so.

BEAUTY EQUALS HEALTH does not claim to treat or cure any condition, illness or disease.

Cancellations and Rescheduling:

We at BEAUTY EQUALS HEALTH understand that sometimes a client may need to cancel or reschedule an appointment. We do require a minimum of a 24-hour notice for cancellations or rescheduling of appointments, to ensure therapist and facilities availability, for other clients. **No call/No shows will be charged 100% of total services scheduled for that day.**

Refund Policy:

If you purchase additional Hydrocolonic procedures and do not wish to use your purchase, we will gladly give you a refund of your purchase price minus a processing fee of $35.00.

_____ Initials

I have read and understand BEAUTY EQUALS HEALTH'S cancellation/rescheduling policy.

Client Printed Name: _____
Last Name First Name MI

Client Signature: _____ _____
(for clients under age of 18, signature of parent/legal guardian required) Date