LifeCleanse OF ANOKA
COLON HYDROTHERAPY
Let the Healing Begin

2665 4TH AVE N SUITE 101
ANOKA, MN 55303
763.231.7303
www.lifecleanseanoka.com

Confidential Request for Procedure

CLIENT INTAKE

Please PRINT Date: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Height: _____ ft _____ in Weight: _____pounds For Women ONLY; Date of last menstrual cycle: ____/____/____

Are you under a medical provider's care? ☐ No ☐ Yes; Provider's name: _____

Are you experiencing any pain? ☐ No ☐ Yes; where? _____

Do you have hypertension (high BP) ☐ No ☐ Yes; Is it controlled by medicine? ☐ No ☐ Yes

If yes what medicine? _____

Why have you chosen to have Colon Hydrotherapy?

☐ **HEALTH MAINTENANCE Please check all that apply**

☐ Improve Health & Well-Being ☐ Weight Management ☐ Support function of elimination

☐ Support Detoxification Programs: *bowel cleanse, liver cleanse, fasting programs etc...*

☐ **ADDRESS HEALTH CONCERNS Please check all that apply**

☐ Bladder Infection	☐ Constipation	☐ Indigestion	☐ Strain
☐ Bloating	☐ Diarrhea	☐ Laxative use	☐ Vomiting
☐ Blood in stool	☐ Hemorrhoids	☐ Rectal bleeding	☐ Other
☐ BM painful or difficult	__ *internal* __ *external*	☐ Recent barium enema	_____
☐ Burning/itching anus	☐ Infectious disease	☐ Recent colonoscopy	_____

☐ Prep for Procedures (colonoscopy, barium enema, etc...)

CONTRAINDICATIONS: Please ☑ and **DATE** if you have ever had any of the following:

☐ Abdominal hernia	_____/_____/_____	☐ Diverticulosis/itis	_____/_____/_____
☐ Abdominal surgery	_____/_____/_____	☐ Dialysis	_____/_____/_____
☐ Abdominal distention	_____/_____/_____	☐ Fissures/fistulas	_____/_____/_____
☐ Acute liver failure	_____/_____/_____	☐ Hemorrhaging	_____/_____/_____
☐ Anemia	_____/_____/_____	☐ Intestinal perforations	_____/_____/_____
☐ Aneurysm (all types)	_____/_____/_____	☐ Lupus	_____/_____/_____
☐ Carcinoma of the colon	_____/_____/_____	☐ Pregnant—due date	_____/_____/_____
☐ Cardiac Condition	_____/_____/_____	☐ Rectal/colon surgery	_____/_____/_____
☐ Cirrhosis of the liver	_____/_____/_____	☐ Renal insufficiencies	_____/_____/_____
☐ Crohns Disease	_____/_____/_____	☐ Other:_____	_____/_____/_____
☐ Colitis	_____/_____/_____	☐ Other:_____	_____/_____/_____

I have **NOT** been diagnosed with any contraindications (see above) for colon hydrotherapy. *please initial* _____

AWARENESS:

I am aware adverse events such as perforation, injury and illness have been alleged and claimed with the use of colon hydrotherapy and/or enema devices. Should I experience resistance during the nozzle 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 that certified therapists do not diagnose, prescribe, or cure/treat any condition or disease. *please initial* _____

MEDICATION NOTICE:

If you are currently taking any medication for any condition, prescription or over the counter, you may want to check with your health care provider before receiving colonic irrigation. ***If you have ever been diagnosed with any intestinal condition or have taken any medication that can weaken the intestinal walls, you should check with your Primary Health Care Provider before receiving colonic irrigations.*** If you are not sure of the side effects of the drugs you are using, you can check on the internet or with your local pharmacist or Doctor. *please initial* _____

Please list any medications you are on

_____ _____ _____ _____

_____ _____ _____ _____

BILL OF RIGHTS:

I have received a copy of the Complementary and Alternative Health Care Client Bill of Rights. I have read and understand the Client Bill of Rights, or it has otherwise been read to me. I have had a full opportunity to ask questions I have about this document and my rights as a client. I understand my rights as a client.

please initial _____

CLIENT ACKNOWLEDGEMENT

I understand the risks that may be associated with colonic irrigation and take full responsibility for any adverse effects that may arise from my use of this device. I understand and take full responsibility for my personal health by informing my colon therapist of any and all medications or conditions that might cause adverse effects during a colonic irrigation.

PREPAID DISCOUNTED SESSION PACKAGES SOLD AS FOLLOWS:

1. All Prepaid Discounted Colonic Sessions are to be used within six (6) months of purchase.
2. No Show appointments are counted as a used session without a 12 hour advance cancellation.
3. Health History should be updated after twelve sessions.
4. No Refunds. Non-Transferable

POSSIBLE SIDE EFFECTS AND PRECAUTIONS:

Increased Energy, Nausea, Vomiting, Cramping, Light headed, Excessive Gas or Bloating, Overheating, Diarrhea, Headaches, Temporary Increase in Body Odor, Joint or Body Aches, Water Over Temperature, Perforation of Rectum/Colon, Hemorrhoids (which may be irritated, inflamed or bleed), Increased Appetite, Over Hydration (when multiple colonic sessions are done during a short period of time).

Client Signature: _____ Date: _____/_____/_____

For clients under 18, the signature and attendance of the parent or guardian for insertion is required

Parent/Guardian Signature: _____ Date: _____/_____/_____

I have reviewed this form with the client:

Therapist or Associate Signature: _____ Date: _____/_____/_____

Accordance with Minnesota Laws statue 146A