



HEALTH HISTORY QUESTIONNAIRE FOR COLON HYDROTHERAPY

(Please print and answer all questions)

NAME _____ Cell _____ Work _____ Today's Date ____|____|____
ADDRESS _____ City _____ State _____ Zip _____
Email _____ Occupation _____
Height _____ Weight _____ Age _____ Date of Birth _____
Are you under a Physicians care? _____ Name _____ Type _____
(ICE) In Case of Emergency contact _____ Relation _____ Phone _____

What is a Contraindication? (con-tra-in-di-ca-tion) A contraindication is a specific health condition in which a drug, disease, procedure, treatment or surgery is inadvisable, as it may be harmful to the health of the client/patient.

Please check all items that apply.

- | | | |
|----------------------------------------------|--------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Abdominal Hernia | <input type="checkbox"/> Dialysis Patient | <input type="checkbox"/> Hemorroids |
| <input type="checkbox"/> Abdominal Surgery | <input type="checkbox"/> Diverticulosis/Diverticulitis | <input type="checkbox"/> Internal <input type="checkbox"/> External |
| <input type="checkbox"/> Abnormal Distension | <input type="checkbox"/> Fissures & Fistulas | <input type="checkbox"/> Rectal / Blood in Stool |
| <input type="checkbox"/> Acute Liver Failure | <input type="checkbox"/> Hemorrhaging | <input type="checkbox"/> Recent Colonoscopy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Use Laxatives |
| <input type="checkbox"/> Aneurysm—All Types | <input type="checkbox"/> Intestinal Perforations | <input type="checkbox"/> BM Painful /Difficult |
| <input type="checkbox"/> Cancer-Type _____ | <input type="checkbox"/> Lupus | <input type="checkbox"/> Burning / Itching Anus |
| <input type="checkbox"/> Cardiac Condition | <input type="checkbox"/> Pregnant (due date _____) | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Crohns Disease | <input type="checkbox"/> Rectal / Colon Surgery | <input type="checkbox"/> Vomiting <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Renal Insufficiencies | <input type="checkbox"/> High Blood Pressure |
| | | <input type="checkbox"/> Infectious Disease |
| | | <input type="checkbox"/> Date of Last Menstrual |
| | | <input type="checkbox"/> Allergic to Latex |
| | | <input type="checkbox"/> Bladder Infection |
| | | <input type="checkbox"/> Infectious Disease |
| | | <input type="checkbox"/> Other _____ |

Notes on the items checked. Please include any pertinent dates:

I have NOT been diagnosed with any Contraindications for colon hydrotherapy: *Initial* _____

Please read and initial:

- I am aware that this clinic uses FDA colon hydrotherapy device's and the trained therapist is not required to be State licensed. This clinic does have a Licensed Medical Director that may NOT be on site. No studies have been conducted for this alternative and complementary modality.
- I am aware adverse events such as perforation, injury and illness have been alleged and claimed with the use of colon hydrotherapy devices and/or Enema kits.
- Should I experience resistance during my 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. If you are taking medications that may increase the risk for potential side effects, then you should consult with your physician before proceeding with your colonic.
- I have read and understand my responsibilities for colon hydrotherapy sessions: *Initial* _____

I have reviewed and discussed with the LIBBE Device Trained Therapist that I do not have any diseases, contraindications or other health concerns and I wish to proceed with my colon hydrotherapy sessions.

CLIENT SIGNATURE _____ Date ____|____|____

As a trained therapist, I will always follow the LIBBE manufacture operation, use & maintenance guidelines. I have reviewed and discussed this form with above client.

THERAPIST SIGNATURE _____ Date ____|____|____

How did you hear about Lifecleanse Anoka?

☐ Physician ☐ Friend ☐ Paper ☐ Family
☐ Coupon (source) ☐ Internet ☐ Colonic Net ☐ Sign
 Other? *(please list)* _____

Client first session evaluation:

Y | N Did your therapist review contraindication symptoms
 and inquire about other health issues?
 Y | N Were rooms clean (changing, device, rest room)?
 Y | N Were you covered comfortably?
 Y | N Were the results satisfactory?
 Y | N Will you recommend to family/friend?
 Y | N Were there any problems/discomfort during your session?
 Explain: _____

How do you feel? _____

12-PREPAID SESSIONS

DATE	THERAPIST	CLIENT

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. No refunds! Non-transferable!

Client Signature _____ Today's Date ____|____|____

Possible Side Effects: Increased energy, nausea, vomiting, cramping, light headed, excessive gas or bloating, overheating, diarrhea, headaches, temporary increase in body odor, joint or body aches, increased appetite, hemorrhoids: *(which may be irritated, inflamed or bleed)*

Precautions: over hydration: (may occur *when multiple colonic sessions are done during a short period of time*) perforation of rectum / colon, irritation / inflammation / allergic reactions of the rectum due to lubricant, water over temperature, other issues when colonic equipment is improperly used, failure to use approved disinfectants or perform the monthly and annual maintenance to prevent bacteria growth and/or operated by untrained therapists.