



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 ___|___|___

