

# Wellmore Mind & Body Center

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## Health History Questionnaire for Colon Hydrotherapy

Please **Print** and Answer all Questions:

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Male/Female \_\_\_\_\_

E-Mail: \_\_\_\_\_ Occupation: \_\_\_\_\_ How long? \_\_\_\_\_

Are you under a Physicians Care? \_\_\_\_\_ Physician's Name \_\_\_\_\_ Type \_\_\_\_\_

(ICE) In Case of Emergency contact: \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

What is a contraindication? A contraindication is a specific health condition in which a drug, procedure, treatment or surgery is inadvisable, as it may be harmful to the health of the patient.

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

Abdominal Hernia

Dialysis Patient

Abdominal Surgery

Diverticulosis / Diverticulitis

Abnormal Distension

Fissures & Fistulas

Acute Liver Failure

Hemorrhaging

Anemia

Hemorrhoidectomy

Aneurysm - All Types

Intestinal Perforations

Cancer - Type \_\_\_\_\_

Lupus

Cardiac Condition

Pregnant-due date \_\_\_\_\_

Crohns Disease

Rectal / Colon Surgery

Colitis

Renal Insufficiencies

Allergic to Latex

Bladder Infection

Bloating \_\_\_\_\_ Vomiting

BM Painful / Difficult

Burning/ Itching Anus

Constipation/ Diarrhea

High Blood Pressure

Infection Disease

Hemorrhoids:

Internal \_\_\_\_\_ External \_\_\_\_\_

Rectal or Blood in Stool

Recent Colonoscopy

Use Laxatives

Date of Last Menstrual

Please check (  ) & Date if you have any above contraindications\*.

I have NOT been diagnosed with any contraindications for colon hydrotherapy: Client Initials X \_\_\_\_\_

I am aware that this colon irrigation and enema device center has a Licensed Medical Director that may NOT be on site. I am aware adverse events such as perforation, injury and illness have been alleged and claimed with the use of colon irrigation and 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 Trained Therapists do not insert, diagnose, prescribe and do not cure or treat any condition or disease.

I have read and understand my responsibilities for colon hydrotherapy session: Client Initials X \_\_\_\_\_

(See a more complete list of possible side effects on back of form.)

I have reviewed and discussed with the LIBBE Device Trained Therapist that I do not have any Contraindications or any Health Concerns and I wish to proceed with my colon hydrotherapy sessions:

CLIENT SIGNATURE: X \_\_\_\_\_ Date \_\_\_\_\_

(For clients 18 or under, the signature & attendance of the parent or guardian for insertion is required.)

I have reviewed this form with my client. Therapist Signature: X \_\_\_\_\_

Have you recently taken any of the following? (Please circle) Aspirin, Aleve, Advil, Ibuprofen, Naproxen, Celebrex, Dolobid, Orudis, Relafen, Feldene, Voltaren, Indocin, Clinoril, Tolectin, Lodine, Toradol, Daypro, Prednisone, Methotrexate, Warfarin, Digoxin, Carvedilol, Coreg, Atorvastatin or other statin to lower cholesterol such as Lipitor, Zocor, Lescol, Mevacor, Pravachol, Plavix, Furosemide or any other diuretic.

Please list any other medications: \_\_\_\_\_

Please explain if you taken any of these medications above: \_\_\_\_\_

**ATTENTION: 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: **X** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(For Clients 18 or under, the signature & attendance of the parent or guardian for insertion is required.)

**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, not maintained properly or operated by untrained therapists.

Please answer the questions below after the first colonic session

**First Session Evaluation: (Please circle)**

Did Therapist review Health History and inquire to any health issues? ( Yes / No )

Were Device, Room, and Restroom clean? ( Yes / No )

Were you covered and comfortable? ( Yes / No )

Were your results Satisfactory? ( Yes / No )

Will you recommend to family/friends? ( Yes / No )

Problems or discomfort during session? ( Yes / No )

If yes please explain: \_\_\_\_\_

How do you feel? \_\_\_\_\_

How do you hear about us? \_\_\_\_\_

CLIENT SIGNATURE: **X** \_\_\_\_\_