ANTIDOTE

Wellness Therapies

COLONIC

Health Intake Form

Please complete the following questions carefully. All data is confidential to ensure your privacy.

Name:____

Address:____

City:____________________________________ State:_________________________ Zip:_____________

Occupation:_________________________________ Employer:____

Phone # ____Send text reminders to this phone? ________

Email Address: ____May we contact you at this email address? _____

Emergency Contact_______________________________________ Phone #________________________________

Birthdate_________________________________ Height ___________ Weight __________ Female____ Male____

Marital Status__________________ # of children___________

How did you hear about us?____

Medical Care: Date of most recent visit to a Primary Care Physician (PCP) _________________________________

Are you currently receiving healthcare by MD/ND/Homeopath doctor(s) __________________________________

If so: please explain: (*Blood Sugar or Thyroid issues, High Blood Pressure or Cholesterol issues, etc.)*

____

____

Allergies: (list all known) ____

Colonic History: have you ever had a colonic before? ________ If so, when?_______________________________

Type of device used (Colonic system) *circle all that apply.* Closed Open Gravity Not Sure

Bowel Habits: how often do you have a bowel movement? 3/day 2/day 1/day skips days

How are your bowel eliminations normally? Requires straining Effortless

Amount: normal too little too large **Consistency:** normal too hard very soft diarrhea

Color: brown black whitish greenish **Other:** lot of mucus lots of gas foul smell

Is the gas related to certain food(s) ___________ if yes, please describe_____________

Are your bowel movements complete? __________________________ Other complaints:____________________

Have you seen a doctor about them?____

Do you use a stool softener or laxative? ___________ Herbal Laxative?_________ Suppository?_______________

If yes, how often?_________________ If yes, how long (days, months, years)?________________

Do you have hemorrhoids or other rectal problems (itching, fissures, etc.) ________________________________

If yes, please describe:____

Energy: On a scale from 1-10 where 1= "can't get out of bed" and 10= optimal energy"

Please rate your normal energy level_________________ Any relation to food or drinks_______________________

If yes, describe examples:____

Diet: What type of diet best describes your **general dietary habits?** *(circle the best response)*

Junk food/fast food eater combination (from junk food to health conscious) vegetarian

Vegan raw macrobiotic natural food eater (over 50% organic) health conscious

Water: how much water do you drink per day? __________ glasses or ___________________ounces

Water Source: Tap (from city or well) Bottled Filtered Boiled Whatever is available

Parasites: Do you know if you have parasites? ___________ If yes, please describe:_________________________

Back Issues? ____________________ Problems or pain in the lower lumbar region?___________________________

IF yes, please describe____

Abdominal area surgeries: *(circle all that apply)*

C– Section Gallbladder Gastric Bypass Hysterectomy Lap Band Vaginal Mesh

Other:____

If yes to any of the above, do you feel that you have had a change in bowel habits? __________________________

Digestion: How is your digestion? (*Circle all that apply)*

Adequate Poor Acid Reflux Bloating Burning/pain in stomach Indigestion Ulcers

Please describe any other problems: ____

____

Medications & Supplements: List all you take regularly, including over the counter: ___________________________

____

Do you take digestive aids? ________________ If yes, please describe:_____________________________________

When was the most recent time you took antibiotics? ____

Smoking: Do you smoke?__________ If yes, how much? ______________ How long?_______________

Alcohol: Do you drink? __________ If yes, how much?______________ How long?_______________

For pre-menopausal women: **Monthly Cycle:** Do you experience PMS? ________

Are your periods more than six days?_______________ Are you susceptible to chronic yeast infections?_________

Do you have any specific concerns? ________________ If yes, please explain:_______________________________

____

____

The following is a list of contraindications for colon hydrotherapy:

Uncontrolled Hypertension
Cirrhosis of the Liver
History of Aneurysm/Blood Clots
Severe Anemia
GI Hemorrhage/Perforation
Congestive Heart Failure
Carcinoma of the Colon
Recent Abdominal Surgery
Pregnancy/First & Last Trimester
Bleeding/Inflamed Hemorrhoids
Abdominal Hernia
Active Diverticulitis
Renal Insufficiency
Fissure/Fistula
Recent Abdominal Surgery

Financial and Cancellation Policy

Initial Visit: $119.00 **Regular Session $100.00**

As a small business owner, and sole practitioner, I need to maximize my available appointment times and manage cancellations.

Starting January 1, 2023 I will be enforcing a 48 hour cancellation policy. *If you do not cancel/reschedule your appointment at least 48 hours prior, you will be charged a **$30.00** non-refundable cancelation fee. The scheduling system confirms your appointment via text 48 hours in advance, however, it is ultimately your responsibility to ensure I am notified.

*All initial consultations will be charged a **$50.00** booking fee. (To be credited to initial appointment)

*A debit/credit card is required to be on file .

____ Date:_______________________

Client Signature

Release Statement:

I acknowledge that *Antidote Wellness Therapies,* LLC and it's staff members are not medical doctors. I understand the *Antidote Wellness Therapies,* LLC staff may suggest nutritional and other health related information to help me attain and maintain my best health. I understand that the practitioners and support staff **DO NOT** diagnose, treat, or claim to cure any illness or disease.

I have been made aware of all contraindications for all modalities on premises and am here on this day and any subsequent visits by my choice and solely on my own behalf. I hereby release and discharge practitioners with *Antidote Wellness Therapies,* LLC from and all claims which I or my agents ever had, now have, or may have relating to or arising out of service provided or recommendations that I have received. I acknowledge that it is my responsibility to consult with my physician or health care providers pertaining to any disease or condition that I may have.

I give permission to share my health information with other practitioners and health care providers professionals who are also providing services for my care.

I have read this informed consent and contraindications in it's entirety and understand it. I am not a minor (under age 18).

I understand the above Financial and Cancelation Policy and agree to abide by these charges.
I am signing this release voluntarily.

____ Date:_______________________

Client Name (Signature)

____ Client Name *(please print clearly)*

COLON HYDROTHERAPY/COLONIC INFORMED CONSENT

I, ____, have decided to undergo a Colonic Hydrotherapy/Colonic procedure.

A colonic is intended to clean the colon by removing build up in the large intestine. The colon is filled and emptied with filtered water either warm or cold. I understand that there may be benefits resulting from this procedure, however, I understand and agree that no warranties have been made as to the effectiveness or outcome of this procedure.

I understand that either the colon hydrotherapy practitioner will insert a tube into my colon, and agree that I will witness the practitioner using sterile and new instruments. Following the procedure I will witness the proper disposal of the nozzle that was used.

The possible side effects of Colon Hydrotherapy include, but are not limited to:

1.) Perforation of colon, the risk of which increases with age and I agree that I am not over the age of 65. _________Initial
2.) Allergic reaction to nozzle __________Initial
3.) Electrolyte imbalance. In order to lessen the risk of this of this complication I agree to use the probiotic supplement the facility/practitioner has provided. ________ Initial
4.) Infection from contaminated equipment ________Initial

I understand that Colon Hydrotherapy should be avoided by people suffering from diverticulitis, Crohn's disease, ulcerative colitis and severe tumors or hemorrhoids in the rectum. It should also be avoided soon after a bowel surgery. People suffering from kidney or heart problems should also avoid regular colon hydrotherapy. People suffering from bowel, anal or rectal pathologies should avoid colon hydrotherapy because the pathology may contribute to the risk of bowel perforation ________________Initial

I understand that certain medical treatments may have adverse effects on a persons of young age and agree that I am not under the age of 18. ______________Initial

I confirm that I am not a woman who is pregnant, nursing or trying to become pregnant as this would make me an unsuitable candidate for this procedure. __________Initial

This list is not meant to be inclusive of all possible risks associated with colon hydrotherapy as there are both known and unknown side effects associated with any medication or procedure. ____________Initial

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees, should this be required.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent for this colon hydrotherapy treatment and release the practitioner and the facility from liability associated with this and subsequent treatments with the above understood.

Client Signature ____ Date:________________________

Wellness Therapies

MASSAGE

Health Intake Form

Please complete the following questions carefully. All data is confidential to ensure your privacy.

Name:____

Address:____

City:____ State:___________________________ Zip:______________

Occupation:___________________________________ Employer:____

Phone # ____Send text reminders to this phone? _________

Email Address: ____May we contact you at this email address? _____

Emergency Contact____ Phone #___________________________________

Birthdate___________________________________ Height ____________ Weight ___________ Female____ Male____

Marital Status___________________ # of children____________

How did you hear about us?____

Medical Care: Date of most recent visit to a Primary Care Physician (PCP) ____________________________________

Are you currently receiving healthcare by MD/ND/Homeopath doctor(s) _____________________________________

How would you rate your general health? Excellent______ Good_______ Fair_______ Poor________

Have you had a professional massage before? Yes ___________ date of last treatment_______ No_______

Please list any allergies or hypersensitiveness

____
____
____
____
____

Reason for initial visit:

____
____
____
____
____

Please list current medications & conditions being treated

____
____
____
____
____

Any major accidents or injuries? Include dates

____
____
____
____
____

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Antidote Wellness Therapies

MASSAGE

Health Intake Form

HEAD NECK

- ○ Headaches / migraines
- ○ Vertigo / dizziness
- ○ Ringing in ears
- ○ Hearing loss
- ○ Vision problems
- ○ Vision loss

RESPIRATORY

- ○ Asthma
- ○ Shortness of breath
- ○ Chronic cough
- ○ Bronchitis
- ○ Emphysema
- ○ Sinusitis
- ○ Frequent colds
- ○ Smoker
- ○ Family history of respiratory difficulties

NERVOUS SYSTEM

- ○ Sensory loss / change
- ○ Numbness / tingling
- ○ Sciatica
- ○ Epilepsy
- ○ Seizures
- ○ Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- ○ Arthritis
- ○ Family history of arthritis
- ○ Osteoporosis
- ○ Tendonitis
- ○ Bursitis
- ○ Jaw pain (TMJ)
- ○ Pins / plates / wires / artificial joint

REPRODUCTIVE

- ○ Pregnant
- ○ Given birth
- ○ Gynecological problems

CARDIOVASCULAR

- ○ High blood pressure
- ○ Low blood pressure
- ○ Heart attack
- ○ Stroke
- ○ Heart disease
- ○ Poor circulation
- ○ Phlebitis / varicose veins
- ○ Pacemaker
- ○ Hemophilia
- ○ Chronic congestive heart failure
- ○ Family history of cardiovascular problems

SKIN & INFECTIONS

- ○ Hepatitis
- ○ HIV / AIDS
- ○ Herpes
- ○ Tuberculosis
- ○ Lyme disease
- ○ Infectious skin conditions

OTHER CONDITIONS

- ○ Cancer
- ○ Diabetes
- ○ Unexplained weight loss
- ○ Digestive conditions
- ○ Fibromyalgia
- ○ Chronic fatigue syndrome
- ○ Depression
- ○ Anxiety
- ○ Psychiatric disorder
- ○ Other conditions ______________________

____

____

____

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature______________________________ **Date**______________________

Parental Consent to treat minor: **Minor Name Please Print:**______________________________

Parent or Guardian Signature ______________________________