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

Financial and Cancellation Policy

Initial Visit: $150.00 **Regular Session $110.00**

As a small business owner, and sole practitioner,
I need to maximize my available appointment times and manage cancellations.
Starting January 31, 2024 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 **$50.00** 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 non-refundable** 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:_____