



CALM HealthWorks

229 Center St. Auburn, ME 04210 207-784-7287
calmhealth@roadrunner.com www.calmhealthworks.com

COLON CLIENT INTAKE FORM

Last name: _____ First name: _____ Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ M /F _____ Marital Status _____

Home phone: _____ Cell phone: _____ Email: _____

Employer _____ Your occupation: _____ Work phone: _____

EMERGENCY CONTACT INFORMATION:

Name of person: _____ Relationship _____

Address: _____ City: _____ Zip: _____

Home phone: _____ Work: _____ Cell: _____

CLIENT REFERRAL INFORMATION:

Referred by: _____ If referred by a friend, may we thank her or him? YES ___ NO ___

Phone Book _____ Referral _____ Website _____ TV _____ Other _____

Doctor's Name: _____ phone: _____

Please follow the instructions of the Therapist. You must be draped/covered at all times.

Signature: _____ Date: _____



I, _____, hereby **authorize / consent to allow Certified Practitioners and Apprentices** of CALM HealthWorks, LLC, to perform the alternative therapy known as Colon Hydrotherapy. The information I receive today is not medical advice; instead, it is a sharing of knowledge and information from the Therapist's education, research, training, and experience. This is not intended to replace the relationship with your primary health care providers.

As Colon Hydrotherapists, we encourage you to be open to new information on the effectiveness of Colon Hydrotherapy and the fundamental role of diet, exercise, supplementation, stress management and emotional and mental work. We encourage you to make your own health decisions based upon your research and in partnership with your primary health care providers, ND, MD or otherwise.

I acknowledge that the information and service provided is not used to prescribe, recommend, diagnose or treat a health problem or disease. It is not a substitute for medical care.

I further acknowledge that alternative methods of available treatment were discussed with me, and that I was given adequate opportunity to ask questions pertaining to this procedure and the alternative methods. I agree to hold harmless any and all personnel of CALM HealthWorks, LLC from any present or future liability arising from any of these procedures.

Client Signature:

Date:

Therapist Signature:

Date:

Cancellation & Refund Policy:

Cancellations or changes to scheduled appointments must be made 24 hours in advance of the scheduled appointment. Otherwise, you will be billed for the cost of service as a cancellation charge. Any check returned for insufficient funds will be subject to a \$35.00 processing fee. If you are calling after business hours, please leave a message on our voicemail indicating your appointment cancellation. The same charge applies for missing an appointment. All payments for services are nonrefundable. Thank you.

Signature: _____ **Date:** _____



FOR COLON HYDROTHERAPY

How often do you have BM? 1 x a day _____ 2 x a day _____ 2-3 x a day _____ 1 x a week _____ Other _____

Do you use or have you used a laxative? _____ Herbal laxative _____ Stool softener _____ Suppositories _____
 Enemas _____ If so, how often? _____

THE FOLLOWING ARE CONTRAINDICATIONS FOR COLON HYDROTHERAPY:

If any of these currently apply to you, we are not able to treat you with colon hydrotherapy at the present time without written permission from your Primary Care Physician.

- | | |
|------------------------------|---|
| Abdominal Hernia _____ | Diverticulitis _____ |
| Abdominal Surgery _____ | Dialysis Patients _____ |
| Abdominal Distention _____ | Fissures & fistulas _____ |
| Acute Liver Failure _____ | Hemorrhaging _____ |
| Anemia _____ | Hemorrhoidectomy _____ |
| Aneurysm All Types _____ | GI hemorrhage / perforations _____ |
| Carcinoma of the Colon _____ | Lupus _____ |
| Cardiac disease _____ | 1st & 3 rd trimester pregnancy _____ |
| Cirrhosis _____ | Rectal/Colon Surgery _____ |
| Colitis _____ | Renal Insufficiency _____ |

Are you currently taking any medications, which may weaken the intestinal walls? Yes _____ No _____

PLEASE SIGN CONFIRMING YOU DO NOT HAVE ANY OF THE ABOVE CONTRAINDICATIONS:

SIGNATURE: _____ DATE: _____

BM painful / difficult Yes _____ No _____ Bladder infection Yes _____ No _____
 Blood in stool Yes _____ No _____ Burning / Itching Anus Yes _____ No _____
 Infections disease Yes _____ No _____ Hemorrhoids Yes _____ No _____
 Recent barium enema Yes _____ No _____ Recent colonoscopy Yes _____ No _____
 Have you ever had rectal bleeding, if yes, when? _____

Are you under a MD or ND's Care? If yes, please explain: _____

I have never been diagnosed with any contraindications for colon irrigation. I am aware that colon irrigation and enema device user facilities are not physicians and therefore do not insert, diagnose or prescribe. I am aware adverse events such as perforation, injury and illness have alleged and claimed with the use of colon irrigation and enema devices. I am responsible for any own self-insertion; if I experience resistance during the insertion, I will immediately stop my session. If during the session I experience discomfort or pain, I am responsible for immediately stopping my session. This facility does not claim to cure or treat any condition or disease.

Client Signature: x _____ **Date:** ____/____/____

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