COLONIC / MEDICAL HISTORY FORM

15049 Florida Blvd | Baton Rouge, LA 70819
Phone: (225) 225-9396 | Fax: (225) 444-5908

CLIENT INFORMATION

Date: _____ Full name: _____

Cell phone: _____ Email: _____

Address: _____

City: _____ State: _____ ZIP: _____ Date of birth: _____

Occupation: _____ Age: _____ Gender (optional): _____ Weight: _____

Emergency contact: _____ Phone: _____

REASON FOR VISIT AND MEDICAL CARE

Why are you seeking colon hydrotherapy? _____

Currently under medical care? [ ] Yes [ ] No Reason: _____

Medical provider: _____ Currently in pain? [ ] Yes [ ] No

MEDICAL HISTORY - CHECK ALL THAT APPLY AND ENTER DATE

[ ] Abdominal hernia	Date: _____	[ ] Abdominal surgery	Date: _____
[ ] Abdominal distension	Date: _____	[ ] Acute liver failure	Date: _____
[ ] Anemia	Date: _____	[ ] Aneurysm (any type)	Date: _____
[ ] Colon cancer	Date: _____	[ ] Cardiac condition or stroke	Date: _____
[ ] Crohn's disease	Date: _____	[ ] Colitis	Date: _____
[ ] Diverticulosis or diverticulitis	Date: _____	[ ] Anal fissures or fistulas	Date: _____
[ ] Hemorrhage or bleeding disorder	Date: _____	[ ] Hemorrhoidectomy	Date: _____
[ ] Intestinal perforation	Date: _____	[ ] Lupus	Date: _____
[ ] Pregnancy	Date: _____	[ ] Rectal or colon surgery	Date: _____
[ ] Renal insufficiency	Date: _____	[ ] Dialysis or cancer treatment	Date: _____

OTHER SYMPTOMS / HISTORY - CHECK ALL THAT APPLY AND ENTER DATE

[ ] Allergies	Date: _____	[ ] Bladder infection	Date: _____
[ ] Bloating	Date: _____	[ ] Blood in stool	Date: _____
[ ] Painful/difficult bowel movements	Date: _____	[ ] Anal burning or itching	Date: _____
[ ] Constipation or diarrhea	Date: _____	[ ] Anal injury or tear	Date: _____
[ ] Infectious disease	Date: _____	[ ] Hemorrhoids	Date: _____
[ ] Rectal bleeding	Date: _____	[ ] Enema or suppository use	Date: _____
[ ] Straining during bowel movements	Date: _____	[ ] Laxative use	Date: _____
[ ] Vomiting	Date: _____	[ ] Other symptom	Date: _____

Most recent colonoscopy? [ ] Yes [ ] No Date: _____

Inserted foreign objects into your rectum? [ ] Yes [ ] No Last date: _____

Participated in anal sex? [ ] Yes [ ] No Last date: _____

Last menstrual period (if applicable): _____

MEDICAL HISTORY & INFORMED CONSENT

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ADDITIONAL HEALTH INFORMATION

Medications and their purposes: _____

Additional medications: _____

Surgeries or hospitalizations (dates/reasons): _____

Relevant past medical history: _____

Previously received colon hydrotherapy? [ ] Yes [ ] No Where? _____ Date: _____

Days of exercise per week: _____ Approximate daily water intake: _____

Date of last bowel movement: _____ [ ] Painful [ ] Difficult [ ] Neither

POTENTIAL RISKS AND SIDE EFFECTS

Possible effects include temporary bloating, gas, distension, fatigue, nausea, diarrhea, headaches, flu-like symptoms, hemorrhoid irritation or bleeding, anal or rectal injury, irritation or allergic reaction to lubricant, electrolyte imbalance, and rectal or colon perforation. Some complications may require immediate medical attention. This list may not include every possible risk.

CLIENT ACKNOWLEDGMENT

I have disclosed my medical history to the best of my knowledge. I understand that colon irrigation carries risks, including injury, illness, and bowel perforation. I understand that the facility has a licensed medical director who is not on site, and that certified therapists do not diagnose, prescribe, or treat medical conditions. If I experience pain or discomfort, I will notify the therapist and stop the session.

MEDICAL TREATMENT ACKNOWLEDGMENT

I, _____, acknowledge that I am being treated by a medical doctor for:

_____

I voluntarily seek colon hydrotherapy from a trained professional. I understand this service is not intended to treat my diagnosed condition or replace medical care.

RELEASE OF LIABILITY - LEGAL REVIEW REQUIRED

The original form contains an assumption-of-risk and hold-harmless provision naming Ms. Margie Ford, the medical director, prescribing physicians, Utopian Health and Wellness, Inc., Utopian Health and Wellness LLC, and related personnel. The exact release must be reviewed and approved by Louisiana legal counsel before use. This summary does not replace the original release.

CANCELLATION POLICY

I understand that I will be charged the full current cost of the procedure if I do not provide at least 24 hours' notice of cancellation.

SIGNATURES

Client signature: _____ Date: _____

Therapist signature: _____ Date: _____

Physician signature (if applicable): _____ Date: _____

Prescription expiration (if applicable): _____

For clients age 18 or younger, confirm applicable parent/guardian consent requirements.