COLONIC / MEDICAL HISTORY FORM

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

Please print clearly. Update your medical history whenever your health changes.

CLIENT INFORMATION

Date: ____ / ____ / _____ Full name: _____

Cell phone: _____ Email: _____

Address: _____

City: _____ State: _____ ZIP: _____

Occupation: _____ Date of birth: _____ Age: _____

Gender (optional): _____ Weight (optional): _____

Emergency contact: _____ Phone: _____

REASON FOR VISIT AND MEDICAL CARE

Why are you seeking colon hydrotherapy? _____

Currently under a medical provider's care? ■ Yes ■ No Reason: _____

Medical provider: _____ Currently in pain? ■ Yes ■ No

MEDICAL HISTORY — CHECK ALL THAT APPLY

Check any conditions you have experienced and provide relevant dates or details below.

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

OTHER SYMPTOMS / HISTORY

■ Allergies
■ Bloating
■ Painful or difficult bowel movements
■ Constipation or diarrhea
■ Infectious disease
■ Rectal bleeding
■ Recent colonoscopy
■ Laxative use
■ Bladder infection
■ Blood in stool
■ Anal burning or itching
■ Anal injury or tear
■ Hemorrhoids (internal or external)
■ Enema or suppository use
■ Straining during bowel movements
■ Vomiting

Last menstrual period (if applicable): _____ Other: _____

Dates, details, or explanations: _____

MEDICAL HISTORY & INFORMED CONSENT

ADDITIONAL HEALTH INFORMATION

Medications and their purposes: _____

Additional medications: _____

Surgeries or hospitalizations (dates and 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 am voluntarily seeking colon hydrotherapy from a trained professional. I understand that this service is not intended to treat my diagnosed condition or replace medical care.

RELEASE OF LIABILITY — LEGAL REVIEW REQUIRED

Important: The original form contains a broad 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 legal release should be reviewed and approved by Louisiana legal counsel before this revised draft is used. The original release has not been replaced by this summary.

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 or guardian consent requirements before treatment.