

S E R E N I T Y W E L L N E S S

Name:	Date:
Address:	Home Phone:
City, Zip	Work Phone:
Email:	Cell Phone:
Occupation:	Birthdate:
Emergency Contact Name:	Contact Number:
Referred By?	Do you have a Latex Allergy?

A contraindication is any indication or symptom that makes it inadvisable to use a particular therapy. The following are contraindications for colon hydrotherapy. If any of these apply to you we are not able to treat you with colon hydrotherapy at the present time. If you have any of these contraindications you may still be eligible to receive colon hydrotherapy once they have subsided or been eliminated or if you are under the order, guidance and supervision of a qualified physician working with Serenity Wellness.

Please put an "X" in the appropriate box. If you have a prescription from a doctor showing supervision over services here for a particular condition, please check the box to the right of that condition.

Yes?	No?	Condition	Prescription?
		Cancer of the colon or GI (gastro intestinal) tract	
		Acute abdominal pain	
		Recent history of GI or rectal bleeding	
		Congestive Heart Failure	
		Uncontrolled hypertension	
		History of Seizures	
		Carcinoma of the rectum	
		Abdominal surgery	
		Intestinal perforation	
		Abdominal hernia	
		Recent colon or rectal surgery	
		Diverticulitis	
		Recent heart attack	
		General debilitation	
		Vascular aneurism	
		Renal insufficiency	
		Epilepsy or psychoses	
		Severe hemorrhoids	
		Cirrhosis	
		Fissures or fistula	
		Pregnancy	
		Ulcerative colitis	
		Acute Crohn's disease	
		Rectal or abdominal tumors	

- Have you ever had colonics? _____. If so, how many? _____ When? _____
- Other cleansing experiences include: _____

Yes	No	Condition	Describe
		Constipation	
		Diarrhea	
		Spastic colon	
		Irritable Bowel Syndrome (IBS)	
		Indigestion (heart burn/acid reflux)	
		Intestinal gas (bloating)	
		Heavy mucus production	
		Skin Disorders	
		Headaches	
		Bad breath	
		Arthritis	
		Brain fog (loss of concentration)	
		Fatigue (low energy)	
		Parasites	
		Depression	
		Backaches	
		Kidney/bladder Infection	
		Weight issues	
		Candidiasis (yeast overgrowth)	
		Sinus or lung conditions	
		Other	

- What health conditions are you currently being treated for and by whom?

3. Bowel Related Information

- How many bowel movements a day or a week (on average) do you have? _____
- Check all that apply

Stool Consistency	Stool Size	Stool Elimination	Transit Time
Formed	Small	Complete	12 hours
Unformed	Medium	Incomplete	24 hours
Hard	Large	Explosive	2 days
Runny	Pencil thin or flat	Strained	3 days
Other	Other	Other	Don't know

• Please describe your historical use of the following:

- o Antibiotics: _____
- o Birth control: _____
- o Chemical laxatives: _____
- o Tobacco: _____
- o Coffee: _____
- o Pharmaceutical and/or recreational drugs: _____

Are you now, or any possibility of being pregnant? Yes/no

Are you breastfeeding? Yes/no

• Have you ever had abdominal surgeries or pregnancies? What type, how many, & when?

• Do you have pain in any areas of your abdomen or bowel? _____

4. Diet and Lifestyle Information

• Do you buy organically grown fruits and vegetables? ____, dairy and meat? ____

• Circle all that apply to your diet:

Raw foods	Eggs/dairy	Vegan	Vegetarian
Whole foods	Meat	Standard American diet	

• Describe your **daily** liquid intake in ounces (e.g. 8 oz. of water):

Water (filtered?)	Soda	Herbal Tea	Alcohol
Juice	Coffee	Black Tea	Other

• Describe your **daily** intake of the following:

Flour products/Bread	Sugar	Artificial Sweeteners	Soy Products
Dairy Products	Meats	Fried Foods	Fast Food

• Describe any known reactions or allergies to foods: _____

• Describe any known nutritional deficiencies: _____

• Describe your exercise habits: _____

• Describe other types of bodywork you receive: _____

• Rate on a scale (1-10) the stress in your life and describe : _____

• Please list current supplements you are taking:

Fiber: _____

Friendly Bacteria: _____

Digestive Support (enzymes / hydrochloric acid): _____

Other: _____

5. Cleansing Goals:

• How do you feel about the state of your health? What/How would you like that to change?

• Do you have interest in a specific type of cleanse? _____

• Are you or your partner trying to conceive? _____

I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder and does not prescribe medical treatment or pharmaceuticals. It has been made clear to me that colon hydrotherapy is not a cure, substitute for medical examination or diagnosis and that it is recommended that I see a physician for any ailments that I might have. I agree that the therapist is helping me with natural hygiene at my request, and is not diagnosing, nor treating disease, nor practicing any form of medicine.

Serenity Wellness is a members-only wellness club offering detoxification and cleansing services solely to members. Membership is free at this time. Please place your initials to confirm your agreement to the memberships terms. _____

If I cancel, reschedule, or skip an appointment without 24 hour notice, I agree to pay a \$50 fee.

All of the information provided above is, to my knowledge, correct and current.

Signed _____ Date _____

Thank you for choosing Serenity Wellness for your detoxification and health maintenance needs. We look forward to sharing with you on your journey to optimum health and well-being!