Consent – Contraindications for Colon Hydrotherapy

While our detoxification services are considered very safe and effective for most, there are some contraindications that you should be aware of. In many cases, these services may still provide benefit and it is up to your licensed physician to prescribe the most appropriate treatment. For this reason, along with your consent, *we may require a prescription or signed referral from a licensed physician for anyone receiving colon hydrotherapy having a contraindication listed* ***proceed with caution column***. ***Restricted column services will not be provided.***

RESTRICTED **(Cannot do service)**	**PROCEED WITH CAUTION** **(May require doctor prescription)**
☐ Abdominal surgery within 12 weeks ☐ Acute liver failure ☐ Aneurysm ☐ Carcinoma of the colon ☐ Crohn's Disease/Colitis ☐ Dialysis/renal insufficiencies ☐ Diverticulosis/Diverticulitis ☐ Fissures/Fistulas ☐ Hemorrhaging ☐ Intestinal Perforations ☐ Pregnancy ☐ Rectal surgery last 12 weeks ☐ Weighing more than 275 lbs	☐ Abdominal Hernia ☐ On Blood Thinners or NSAIDS ☐ Cardiac Conditions ☐ History of Hemorrhoidectomy ☐ Diagnosis of Lupus ☐ Severe Anemia ☐ Active hemorrhoids ☐ **NONE APPLY – No prescription needed**

1. I have read the list of contraindications for colon hydrotherapy and verify that my answers are true.
2. I understand that I may need a prescription from a physician.
3. If I experience any new health problems or a worsening of existing health problems, I will contact my physician immediately.
4. I understand that it is my responsibility to inform the practitioners at Nourishing Journey of any changes in my health that may be related to the listed contraindications.
5. While the therapist is certified in colon hydrotherapy, I fully understand that colon hydrotherapy is not a licensed profession in the state of Maryland. I acknowledge that I am responsible for inserting the tube required for the session and that the therapist is not licensed to do this for me. If I would like assistance with the insertion of the tube, I will ask the therapist and I give permission to the therapist to be of assistance. I also understand that the therapist cannot be held liable in doing so.

My signature below signifies that I have read and understand what is written above.

Client/Guardian Signature: _____ Date Signed: _____

Client/Guardian (printed): _____

Client Name if Minor: _____

Nourishing Journey

Name: _____

Date: _____

Bowel Movement Questionnaire (For colonic services only):

1. Do you experience frequent cramping or gas?
   - ☐ Yes
   - ☐ No
2. Do you experience frequent bloating?
   - ☐ Yes
   - ☐ No
3. Do you have loose bowel movements after eating certain foods?
   - ☐ Yes
   - ☐ No
4. Do you have mucous in your stool?
   - ☐ Yes
   - ☐ No
5. Your stool consistency is usually
   - ☐ Hard and solid
   - ☐ Soft but still solid
   - ☐ Mushy
   - ☐ Liquid
6. If your stool is solid, is it
   - ☐ Hard balls
   - ☐ Long and formed like a snake
   - ☐ Wide and long
   - ☐ Other Explain:_____
7. How often do you have bowel movements?
   - ☐ Once per week or less
   - ☐ Every 2 or 3 days
   - ☐ Once every day
   - ☐ 2 or 3 times per day
   - ☐ 4+ times per day
8. The color of your stool is typically
   - ☐ Medium brown
   - ☐ Dark brown
   - ☐ Light brown
   - ☐ Yellow
   - ☐ Green