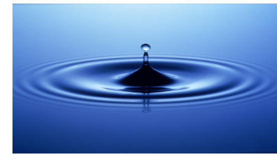
HYDRO HEALTH OF WESTERN MASSACHUSETTS
51 STEARNS AVE
PITTSFIELD, MA 01201
413-464-1493

CONFIDENTIAL HISTORY



bcollingwood@nycap.rr.com

PLEASE PRINT AND ANSWER ALL QUESTIONS

Date: _______ / _______/ 2020

Name ____ Home Phone ___________________________

E-Mail ____ Cell Phone ___________________________

Address ___________________________________ City ______________________ State ______ Zip _________

Height ____________ Weight _____________ Birth Date _______ / _______/ ___________ Age ___________

Occupation _______________________ How Long? ________ Referred By: _____________________________

ARE YOU UNDER A MEDICAL PROVIDER'S CARE? _______ Provider's Name ________________ Prescriptions? _____

Are you in any pain? _______ Where? ____

How often do you have bowel movements? ____________________ Difficult or Straining? Yes / No / Sometimes

WHY HAVE YOU CHOSEN TO HAVE COLON IRRIGATION(S)? ____

PLEASE CHECK (√) ALL THAT APPLY: Right to self-treat ________ Good Health ________ Lose Weight ________

_____ Bloating _____ Burning/itching anus _____ Rectal bleeding _____ Infectious disease

_____ Blood in stool _____ Constipation _____ Use of Laxatives _____ Recent Barium Enema

_____ BM painful _____ Diarrhea _____ Vomiting _____ Recent Colonoscopy

_____ BM difficult _____ Hemorrhoids _____ Bladder Infection Other: _________________

CONTRAINDICATIONS: Please DATE if you have ever had any of the following:

___/___/___ Abdominal Hernia	___/___/___Colitis	__/__/__ Colon/Rectal Surgery
___/___/___Abdominal Surgery	___/___/___Dialysis	___/___/___ Renal insufficiency
___/___/___Abnormal Distention	___/___/___Diverticulosis/Diverticulitis	___/___/___ Hypertension
___/___/___Acute Liver Failure	___/___/___Hemorrhaging	___/___/___ Fissures/Fistulas
___/___/___Anemia	___/___/___Hemorrhoidectomy	Currently on medications that may weaken intestinal walls:
___/___/___Aneurysm - all types	___/___/___Intestinal Perforations	______________________________
___/___/___Carcinoma of Colon	___/___/___Lupus	______________________________
___/___/___Crohn's Disease	___/___/___Pregnant (due date)	______________________________ ______________________________

I have not been diagnosed with any contraindications for colon irrigation, *see above*. I am aware that colon irrigation and enema device facilities are not physicians and therefore do not insert, diagnose or prescribe. I am also aware adverse events such as perforation, injury and illness have been alleged and claimed with the use of colon irrigation and enema devices. I am responsible for my own insertion in privacy; if I experience resistance during my insertion, I will immediately stop my session. If during the session I experience pain, I am responsible for immediately stopping my session. By signing, I acknowledge this facility does not claim to cure or treat any condition or disease. **IF ANY CONTRAINDICATIONS ARE NOTED, PROVIDE A WRITTEN PRESCRIPTION FROM A PHYSICIAN FOR COLON HYDROTHERAPHY ON AN AS NEEDED BASIS.**

CLIENT SIGNATURE____ **DATE** ________ / ________ / **2020**

- ***For clients 18 or younger, signature & attendance of the parent or guardian is required for insertion ****

I have reviewed this form with my client. COLON HYDROTHERAPIST SIGNATURE ____