NEOMED
Institute of Wellness and Rehabilitation

Neomed Institute of Wellness and Rehabilitation
P.O. Box 21, Moni, Limassol, CY 4525
+357 25259988, info@neomedinstitute.org

Colon Hydrotherapy Clients Intake Form & Health Conditions

NAME: ____ DATE: _______/________/__________

ADDRESS: ____ CITY: __________________ ZIP: ______________

PHONE: ________________________ CELL: ___________________ DATE OF BIRTH: ______/_____/________

EMAIL: ____

HAVE YOU EVER HAD A COLON HYDROTHERAPY: ☐YES ☐NO IF SO, HOW MANY: _____________________

OVER WHAT PERIOD: ____ LAST COLONIC_____/_____/______

HOW MANY BOWEL MOVEMENTS PER DAY DO YOU USUALLY HAVE? ______________________________

HOW WOULD YOU BEST DESCRIBE YOUR BOWEL MOVEMENTS? __________________________________

STRAINING? _______________ WITH EASE? _______________ DISCOMFORT? ______________

HAVE YOU EVER HAD A BARIUM ENEMA? ☐YES ☐NO WHEN? _________________________________

HAVE YOU EVER HAD A SIGMOIDSCOPY? ☐YES ☐NO WHEN? _________________________________

HAVE YOU EVER HAD A COLONSCOPY? ☐YES ☐NO WHEN? _________________________________

DESCRIBE THE TYPE AND FREQUENCY OF YOUR DISCOMFORT AS WELL AS ANY ACTIVITY THAT AGGREVATES THE CONDITION: (EX: DULL, SHARP, OFF & ON, WHEN STANDING, DRIVING, SITTING, ETC)

____

____

ANY OTHER RECTAL PROBLEMS: (EX: BLEEDING)

____

____

ANY ABDOMINAL INJURIES?

____

____

ANY PELVIC OR HIP INJURIES?

____

____

WHEN WERE YOU AWARE OF THIS PROBLEM? ____

____

WHAT CAUSED IT? ____

IS THE PROBLEM GETTING WORSE? ____

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DO YOU USE A STOOL SOFTNER OR LAXATIVE? ☐YES ☐NO SPECIFY _________ DO YOU USE HERBAL LAXATIVES? ☐YES ☐NO DO YOU CURRENTLY HAVE HEMORRHOIDS? ☐YES ☐NO DO YOU DRINK CHLORINATED WATER? ☐YES ☐NO	DO YOU DRINK CARBONATED DRINKS? ☐YES ☐NO DO YOU USE TOBACCO PRODUCT? ☐YES ☐NO TAKE HERBAL/VITAMIN SUPPLEMENTS? ☐YES ☐NO HOW MUCH WATER DO YOU DRINK IN A DAY: _________ GLASSES

Contraindications for Colon Hydrotherapy

• SEVERE CARDIAC DISEASES: UNCONTROLLED HYPERTENSION • CONGESTIVE HEART FAILURE OR VALVE DISEASE • ANEURYSM • SEVERE ANEMIA • GI HEMORRHAGE / PERFORATION • SEVERE HEMORRHOIDS • CIRRHOSIS	• CARCINOMA OF THE COLON OR RECTUM • FISSURES / FISTULAS • ADVANCED PREGNANCY • ABDOMINAL HERNIA • RECENT COLON OR RECTAL SURGERY • RENAL INSUFFICIENCY • ADVANCED CHRON'S DISEASE • ADVANCED ILETIS OR ILECOLITIS

Colon Hydrotherapy is an effective method of cleansing the large intestine (colon). Your therapist does not diagnose diseases or prescribe medication. It is your responsibility to provide pertinent health information and to inform the therapist of any changes. The office will provide a form to assist you in collection from your insurance company, however, services rendered are payable at the time of service unless special arrangements have been made prior to your appointment. We reserve the right to refuse service if client is under the influence of illegal drugs or alcohol.

IF YOU HAVE ANY OF THE ABOVE LISTED CONDITIONS COLON HYDROTHERAPY CANNOT BE DONE!

Please sign that you have reviewed the contraindication list.

Signature_____________________________ **Date:** ________________

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Please Place one check mark next to each condition. Mark whether you HAVE HAD that condition within the past 30 day OR... If you HAVE HAD that condition in the past.

Within 30 days	**past**		Within 30 days	**past**		Within 30 days	**past**	
☐	☐	ABDOMINAL PAIN	☐	☐	DIVERTICULITIS	☐	☐	LAXATIVES
☐	☐	AIDS/HIV	☐	☐	DIVERTICULOSIS	☐	☐	LIVER TROUBLE
☐	☐	ALLERGIES	☐	☐	DRY SKIN	☐	☐	LOW BLOOD SUGAR
☐	☐	ANEMIA	☐	☐	EMPHSEMA	☐	☐	LYMPHNOMIA
☐	☐	ANTIBIOTIC USE	☐	☐	ENLARGED THROID	☐	☐	MENOPAUSE
☐	☐	ARTHRITIS	☐	☐	FAMILY HISTORY OF COLON CANCER	☐	☐	NERVOUSNESS
☐	☐	ASTHMA	☐	☐	FATIGUE	☐	☐	ORGANIC FOODS
☐	☐	BACKACHES	☐	☐	FREQUENT HEADACHES	☐	☐	OVERWEIGHT
☐	☐	BELCHING	☐	☐	FIBRIMYALGIA	☐	☐	PAINFUL MENSTRATION
☐	☐	BIRTH CONTROL PILLS	☐	☐	FISTULA/FISSURE	☐	☐	PARASITES
☐	☐	BLOATING	☐	☐	FLATULENCE/GAS	☐	☐	PMS
☐	☐	BLOODY/BLACK STOOL	☐	☐	GALLBLADDER	☐	☐	POOR CIRCULATION
☐	☐	BLURRED VISION	☐	☐	HEARING PROBLEMS	☐	☐	PROCESSED FOODS
☐	☐	BODY ODORS	☐	☐	HEART PROBLEMS	☐	☐	PROSTRATE PROBLEMS
☐	☐	BOWEL IMPACTIONS	☐	☐	HEMORRHOIDS	☐	☐	RECENT CONSTIPATION
☐	☐	BREAST PAIN	☐	☐	HEPATITIS	☐	☐	SHORTNESS OF BREATH
☐	☐	BRONCHITIS	☐	☐	HERNIA	☐	☐	SINUS PROBLEMS
☐	☐	BRUSE EASILY	☐	☐	HERPES	☐	☐	SKIN RASH
☐	☐	CANCER	☐	☐	HIGH BLOOD PRESSURE	☐	☐	ULCERATIVE COLITIS
☐	☐	CHANGE IN STOOL	☐	☐	HIGH CHOLESTEROL	☐	☐	ULCERS
☐	☐	CHRONIC CONSTIPATION	☐	☐	HISTORY OF SEIZURES	☐	☐	UNDER WEIGHT
☐	☐	CHRONIC COUGH	☐	☐	HYPOGLYCEMIA	☐	☐	VAGINAL DISCHARGE
☐	☐	COLITIS	☐	☐	IBS	☐	☐	VISION PROBLEMS
☐	☐	CHRON'S DISEASE	☐	☐	INTEGESTION/REFLUX	☐	☐	VOMITING
☐	☐	CYST/TUMORS	☐	☐	INSOMNIA	☐	☐	WATER RETENTION
☐	☐	DEPRESSION	☐	☐	IRRITABILITY	☐	☐	YEAST INFECTIONS
☐	☐	DIZZINESS	☐	☐	KIDNEY FAILURE	☐	☐	OTHER: PLEASE LIST
☐	☐	DIABETES	☐	☐	KIDNEY STONES	☐	☐	*
☐	☐	DIARRHEA	☐	☐	KIDNEY INFECTION	☐	☐	*
☐	☐	DIFFICULT URINATION	☐	☐		☐	☐	*

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Informed Consent

I, ____________________________ (please state name and surname), give my permission to perform the Colon Hydrotherapy Session as scheduled. I fully understand all the questions above: I have answered them all correctly and honestly.

I have read and reviewed the list of Contradictions for Colonics.

I understand that Colonics performed at the Neomed Institute of Wellness and Rehabilitation are done by a Licensed therapist that have advanced training in Colon Hydrotherapy.

I understand that the doctor and therapist will inform me of what to expect in the course of my treatment and will suggest adjustments to my regimen if deemed necessary. I also am aware that the individual results are dependent upon my age, symptoms, and lifestyle.

I am aware that the doctor and therapist do not diagnose illness or diseases.

I have informed the doctor and therapist of all my known physical conditions and medications, known allergies and I will keep them updated on any changes.

I understand that there shall be no liability on the practitioner's part due to my forgetting or withholding any pertinent information. I release and hold harmless the Neomed Institute of Wellness and Rehabilitation, and the staff from any liability for adverse reactions that may result from this treatment.

I understand I may discontinue the session for if any reason I feel uncomfortable.

This form collects your personal and medical data so that we can add to your medical file. Your data will be processed according to our privacy policy. Check out our privacy policy here for the full story on how we process, manage and protect your personal data.

I consent to Neomed Institute and Neomed Medical Center collect and process my personal data.

[Sgn] ____________________
Name: ____________________
ID/Passport: ______________