

Contraindications

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 cannot treat you with colon hydrotherapy at the present time, unless you have a written prescription from an MD or ND showing supervision over our services for the contraindication. If you have any of these contraindications, you may still be eligible to receive colon hydrotherapy once they have subsided or been eliminated.

- Carcinoma of the colon (cancer)
- GI (gastrointestinal) tract or rectum
- Recent history of GI or Rectal Bleeding
- Cardiac Condition – a heart condition such as uncontrolled hypertension or congestive heart failure.
- Abdominal Surgery – since the administering of this procedure initiates peristalsis and the use of the abdominal muscles may aggravate sutures and the healing of the incision, a minimum of 12 weeks should pass after surgery.
- Intestinal Perforation – tears in the intestinal wall.
- Abdominal/Hiatal Hernia – diagnosed with or has had surgery for abdominal hernia.
- Colon or Rectal Surgery
- Diverticulitis/Diverticulosis – pouches (diverticula) in the intestinal wall. When the pouches become inflamed (diverticulitis), they cause pain and sometimes rectal bleeding
- Recent Heart Attack
- Vascular Aneurism – a sac formed by an enlargement in a weakened wall of an artery, vein or the heart.
- Renal Insufficiency – any deterioration of the kidneys
- Epilepsy or Psychosis
- Severe Hemorrhoids
- Cirrhosis of the liver – a consequence of chronic liver disease characterized by replacement of liver tissue by fibrotic scar tissue as well as regenerative nodules, leading to progressive loss of liver function
- Fissures – minor lacerations in the rectal lining
- Fistulas – a passageway that develops between the rectal wall and the skin surrounding the anus. Severe lacerations require surgical repair
- Pregnancy
- Ulcerative Colitis – inflammation of the colon (usually starts at the rectum)
- Crohn's Disease – patches of inflammation in the intestines which can later cause narrowing of the intestinal tract
- Rectal or Abdominal Tumors
- Abnormal Distension/Masses – diagnosed with an abnormal colon
- Acute Liver Failure – the appearance of severe complications rapidly after the first signs of liver disease (such as jaundice, Hepatitis), and indicates that the liver has sustained severe damage (loss of function of 80-90% of liver cells)
- Anemia- diagnosed with severe anemia (blood is low in red cells)
- Dialysis- used to purify the blood for patients with kidney failure
- Hemorrhaging – flow of bright red blood discharge
- Hemorrhoidectomy – removal of hemorrhoids – a doctor's release should be obtained
- Lupus – chronic inflammatory, autoimmune disease that usually affects the kidneys
- Vagus Nerve/Vasovagal Reflex – The vasovagal reflex is a common cause of fainting. The vagus nerve is connected to the heart and blood vessels. If it is triggered, it can lower your blood pressure and heart rate and make you feel faint.



Health History - Your Health History is Confidential

Name: _____ Birth Date: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Work Phone: (_____) _____ Home Phone: (_____) _____ Cell Phone: (_____) _____
Occupation: _____ Referred by: _____

Have you recently travelled (Date)? _____ If so, your destination? _____

Please place an X in front of each and every symptom/health condition you have or have previously experienced.

General Symptoms

- _____ Headache
- _____ Fever - Currently
- _____ Chills
- _____ Sweats
- _____ Fainting
- _____ Allergies
- _____ Dizziness
- _____ Convulsions
- _____ Loss of Sleep
- _____ Fatigue
- _____ Nervousness/Depression
- _____ Weight Gain/Loss
- _____ Numbness in _____

Skin

- _____ Itching
- _____ Bruises Easily
- _____ Dryness
- _____ Varicose veins
- _____ Sensitive skin
- _____ Hives or allergy

Respiratory

- _____ Chronic cough
- _____ Spitting up phlegm
- _____ Spitting up blood
- _____ Chest pain
- _____ Difficult breathing

Cardio-Vascular

- _____ Rapid heartbeat
- _____ Slow heartbeat
- _____ High blood pressure
- _____ Low blood pressure
- _____ Pain over heart
- _____ Heart attack
- _____ Swelling ankles
- _____ Poor circulation

Eyes, Ears, Nose & Throat

- _____ Crossed eyes
- _____ Eye pain
- _____ Deafness
- _____ Failing vision
- _____ Far sightedness
- _____ Near sightedness
- _____ Earache
- _____ Ear noises
- _____ Ear discharge
- _____ Nose bleeds
- _____ Nasal drainage
- _____ Sore throat
- _____ Swollen tonsils
- _____ Enlarged lymph glands
- _____ Enlarged thyroid
- _____ Colds
- _____ Sinus infection
- _____ Hay fever
- _____ Asthma
- _____ Dental Decay
- _____ Gum problems

Genito-urinary

- _____ Frequent urination
- _____ Painful urination
- _____ Blood in urine
- _____ Kidney problems
- _____ Inability to control urine
- _____ Urinary Tract Infection (UTI)
- _____ Prostate problems

Muscle, bone & joint

- _____ Stiff neck
- _____ Backache
- _____ Swollen joints
- _____ Tremors
- _____ Painful tailbone
- _____ Foot & ankle problems
- _____ Pain in: shoulders, arms, elbows, hands, hips, legs, knees, feet, or other:

- _____ Hernia
- _____ Spinal curvature
- _____ Faulty posture
- _____ Subluxation
- _____ Pinched nerves

Gastro-intestinal

- _____ Poor appetite
- _____ Excessive hunger
- _____ Difficult digestion
- _____ Belching or gas
- _____ Distention of abdomen
- _____ Nausea
- _____ Vomiting
- _____ Pain over stomach
- _____ Vagus Nerve/Vasovagal Reflex
- _____ Constipation
- _____ Diarrhea
- _____ Colon problems
- _____ Hemorrhoids or piles
- _____ Rectal bleeding
- _____ Bloody stools
- _____ Intestinal worms/parasites
- _____ Liver problems
- _____ Gall bladder problems
- _____ Jaundice
- _____ Diverticulosis/Diverticulitis
(If you have diverticulosis or Diverticulitis you are not a candidate for colon hydrotherapy)

This section for Women Only - If not female please continue to next section

- | | | |
|--|---|--|
| <input type="checkbox"/> Painful menstrual periods | <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Excessive menstrual flow | <input type="checkbox"/> Cramps or backache | <input type="checkbox"/> Lumps in breast |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Menopausal symptoms |

For everyone. Please place an "X" in either the Yes or No space for each of the following questions.

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Are you having any pain or discomfort at this time? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you feel very nervous about having colonic irrigation? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Have you ever experienced colonic irrigation? If yes, when? _____ Where? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Have you been a patient in a hospital during the past six weeks? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Have you been under the care of a doctor during the past two years? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Are you taking any prescription medications? If yes, please list current medications: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you taking any supplements or herbal medications? If yes, please list current supplements: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you on a special diet? If yes, please explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Has your medical doctor ever told you that you have cancer or a tumor? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you have any disease, condition, or health problem not listed?
If yes, please explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you <u>lost</u> or <u>gained</u> more than 10 pounds in the past year? Current Weight? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you have abdominal bloating/gas? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you use prescription or over-the-counter laxatives? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have rectal bleeding? |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you have perforated or bleeding hemorrhoids? |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you have to strain to have a regular bowel movement? |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Do you have one or more bowel movements per day? |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Have you had a recent colonoscopy or sigmoidoscopy?
If yes, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Have you had rectal surgery of any type? (i.e.: partially removal of any portion of the colon) |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. Why have you chosen to have colonic irrigation? _____ |

To the best of my knowledge, all the preceding answers are correct.

Client signature: _____ Date: _____

Colonics are a perfectly safe and natural procedure; however, there are some conditions that may not be benefited by the colonic process. Contraindications to colon hydrotherapy include congestive heart failure, intestinal perforation, carcinoma of the rectum, fissures or fistula, severe hemorrhoids, abdominal hernia, renal insufficiency, recent colon or rectal surgery, cirrhosis of the liver, and first and last trimester of pregnancy.

Curing disease or any other illness is between you and your health care medical professional. Internal Wellness Center does not treat any diseases or illnesses, nor do we make any diagnosis of any illness. Internal Wellness Center is not staffed by medical doctors and is not attempting to portray itself as a medical professional, nor does it conduct the activities of medical doctors. Colonic hygiene is considered complementary to the recommendations and/or programs of your health care medical professional.

150 Wood Road, Suite 403 • Braintree, MA 02184 • tel.781.228.6915 • fax.781.228.6916
www.internalwellnessctr.com



Informed Consent

Neither Internal Wellness Center nor its associates, do any of the following, whether implied or intended:

- We do not diagnose.
- We make no attempt to cure any condition.
- We make no claims or imply any claims that suggest a cure for any condition.
- We do not claim that any supplemental material we speak about will cure any condition, or that its purpose is to treat any condition.
- We do not prescribe or treat disease; however, we do attempt to educate you in/on dietary recommendations and exercise, if it is not contradictory to the recommendations of your physician(s).
- I, the undersigned client, understand the above statements.
- I, as the undersigned client, understand that diet and nutrition is an inexact science, and that the results obtained are not always constant or predictable.
- I also understand that there is no guarantee of any results and that the opposite of my desired results may occur.
- Whether or not I participate in this procedure and/or program is my decision, based on my constitutional right of the Ninth Amendment. I must make all decisions related to my wellbeing and health.
- I further understand that Internal Wellness Center staff are not medical doctors and are not attempting to portray themselves or conduct the activities of medical doctors.
- I also understand that the medical device used in this procedure is intended for use in colon irrigation.
- Additionally, I understand the Angel of Water system is registered with the FDA and is intended for colon cleansing to promote general health and wellbeing and when medically indicated, such as preparation for radiological or endoscopic examinations.
- I understand colonic hygiene is considered complementary to the recommendations and/or programs of my health care/medical professional(s).

If any representations have been made to me concerning this program, or if I have any understanding about this program which representations and/or understandings are contrary to the above statements, I will indicate so at the bottom or reverse side of this form. By signing this form, I state that I am not a D.O.H. agent or Federal Agent or in the services of these agencies, but that I am a client seeking colon hydrotherapy services for my own benefit. I have read this agreement in full and agree to its terms.

Print Name: _____ Street Address _____

City _____ State _____ Zip _____ Email address: _____

Work Phone: (_____) _____ Home Phone: (_____) _____ Cell Phone: (_____) _____

Signature: _____ Date: _____

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Policies

Please read, initial each section where indicated and sign below.

Our Financial Policy

Thank you for choosing Internal Wellness Center as your colon rejuvenation provider. We are committed to your colonic session being successfully completed. Please understand that the prompt payment of your bill is the only way we can continue to provide the best quality and service.

_____ We require full payment at the time of service. We accept cash, Master Card, VISA, Discover and American Express. **No personal checks please.**

_____ **Non-Refundable.** Package pricing is due at 1st session. Packages may not be split between two people. Payable by cash or credit card. Sessions up to 6 are good for up to 6mts from date of purchase. Sessions greater than 6 are good for up to 1 year from the date of purchase. **First Session must be prepaid at time of scheduling.**

Missed and/or Late Appointments

_____ Unless **cancelled or rescheduled at least 24 hours in advance**, we will charge for missed appointments at the full rate of the scheduled appointment. This includes Covid/Flu related reasons. Please help us by keeping your appointment.

_____ Late arrival for a scheduled appointment will be accommodated whenever possible. However, due to the scheduling of other clients, late arrivals may need to be rescheduled.

Service Policy

_____ Internal Wellness Center reserves the right to refuse to offer our services to individuals with conditions that we feel may be contraindicated to colon hydrotherapy. Clients who we feel are out of our scope of practice may not receive services without the express written original prescription from a medical practitioner.

Signature: _____ Date _____

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