COLON HYDRO HEALING

CHI NEI TSANG - RELEASE FORM

Date	YYYY / MM / DD

Name		DOB	Gender	Who Referred You?
Surname	Given	YYYY / MM / DD	☐ Male ☐ Female	

Address					Contact Information	
					☐ Residence	( ) -
					☐ Cell	( ) -
Suite #	Street	City	Province	Postal	☐ Email	

Emergency Contact Information			Number
Surname	Given	Relationship	( ) -

General Medical Information	
Occupation	
Physician	
Therapist/Psychologist	
Naturopath/Homeopath	
Chiropractor	
Massage Therapist	
Specialist/Other	

Medical Conditions	Gender
Are you wearing an IUD? Are you pregnant?	☐ Yes ☐ No
Do you suffer from epilepsy or seizures?	☐ Yes ☐ No
Do you have pancreatic?	☐ Yes ☐ No
Have you ever had an ulcer or hernia?	☐ Yes ☐ No
Do you have diabetes? Hypoglycemia?	☐ Yes ☐ No
Do you suffer from digestive problems?	☐ Yes ☐ No
Do you suffer from elimination problems?	☐ Yes ☐ No
Do you suffer from colitis or irritable bowel?	☐ Yes ☐ No
Have you suffered kidney or bladder problems?	☐ Yes ☐ No
Do you experience frequent headaches?	☐ Yes ☐ No

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Have you ever experienced depression or bipolar symptoms?	☐ Yes ☐ No
Do you suffer from arthritis? Joint swelling?	☐ Yes ☐ No
Do you have cardiac or circulatory problems?	☐ Yes ☐ No
Do you have any allergies? Skin conditions?	☐ Yes ☐ No
Have you suffered a sexual trauma?	☐ Yes ☐ No
Do you frequently suffer from stress?	☐ Yes ☐ No
Have you had or do you have cancer?	☐ Yes ☐ No
Have you ever had surgery?	☐ Yes ☐ No
Have you ever been in in an accident; or suffered any injuries in the past year?	☐ Yes ☐ No
Do you suffer from back pain?	☐ Yes ☐ No
Do you have numbness or stabbing pains anywhere?	☐ Yes ☐ No
Are you sensitive to touch or pressure in any areas?	☐ Yes ☐ No
Do you have tension or soreness in any areas?	☐ Yes ☐ No
Do you have high blood pressure?	☐ Yes ☐ No
Do you have any contagious diseases?	☐ Yes ☐ No
Do you have any other medical condition or are you taking any medications we should know about?	☐ Yes ☐ No

All information will be held in strict confidence. This information may help your therapist to assist you better in your quest for optimal colon hydrotherapy results. It is not intended to diagnose or prescribe and is not a replacement for your regular medical attention by your physician. I have read the contraindications for colonic irrigation listed above and with my signature below I testify that I DO NOT HAVE ANY of the listed conditions.

Print Name: _____

Client's Signature: _____

Date: _____