CONTRAINDICATIONS

Date	YYYY / MM / DD

Name		DOB	Gender	
Surname	Given	YYYY / MM / DD	☐ Male ☐ Female	

Do you presently have, or have you had any of the following conditions? If in the past, how long ago? Please circle yes or no:

Cancer of the Colon or GI tract	Yes / No	Vascular aneurysm	Yes / No
Acute abdominal pain	Yes / No	Renal insufficiency	Yes / No
Recent history of GI bleeding	Yes / No	Epilepsy or psychoses	Yes / No
Congestive heart failure	Yes / No	Cirrhosis	Yes / No
Uncontrolled hypertension	Yes / No	Carcinoma of the rectum	Yes / No
History of Seizures	Yes / No	Severe hemorrhoids	Yes / No
Abdominal surgery	Yes / No	Intestinal perforation	Yes / No
Diverticulitis	Yes / No	Fissures or fistula	Yes / No
Recent heart attack	Yes / No	Abdominal hernia	Yes / No
General debilitation	Yes / No	Pregnancy	Yes / No
Recent colon or retal surgery	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: ______________________________

Clients Signature: ______________________________

Date: ______________________________