

Waterstone Medical Bldg.
14100 Cedar Rd.
University Hts., Ohio 44118

Colonic Center of America

Phone 216-916-7757
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Confidential Request for Procedure

Please PRINT and Answer all Questions:

Date: ____/____/20__

NAME: _____ (home ph) _____ (work ph) _____

ADDRESS: _____ City _____ State _____ Zip _____

OCCUPATION: _____ **How Long?** _____

HEIGHT: _____ **WEIGHT:** _____ **BIRTH DATE:** _____ **AGE:** _____

Why have you chosen to have Colon Irrigation Session(s)? Please check (✓) all that apply:

- Reason _____
- Under a Medical Provider's Care? ____ •Medical Provider Name _____ •By Prescription ____
- In Pain? ____ Where? _____

*** Contraindications: (✓) and Date if ever had any of the following:**

DATE

- ____ Abdominal Hernia
- ____ Abdominal Surgery
- ____ Abnormal Distension
- ____ Acute Liver Failure
- ____ Anemia
- ____ Aneurysm - All Types
- ____ Carcinoma of the Colon
- ____ Cardiac Condition
- ____ Crohns Disease
- ____ Colitis
- ____ Dialysis Patients

DATE

- ____ Diverticulosis/Diverticulitis
- ____ Fissures & Fistulas
- ____ Hemorrhaging
- ____ Hemorrhoidectomy
- ____ Intestinal Perforations
- ____ Lupus
- ____ Pregnant -(due date _____)
- ____ Rectal / Colon Surgery
- ____ Renal Insufficiencies
- ____ Taking medication's, which may weaken intestinal walls?

- ____ Bladder Infection
- ____ Bloating
- ____ Blood in Stool
- ____ BM Painful /Difficult
- ____ Burning / Itching Anus
- ____ Constipation
- ____ Diarrhea
- ____ Infectious Disease
- ____ Hemorrhoids
- Internal__ External__
- ____ Rectal Bleeding
- ____ Recent Barium Enema
- ____ Recent Colonoscopy
- ____ Strain
- ____ Use Laxatives
- ____ Vomiting
- ____ Date of Last Menstral
- Other _____

If Any Checked - Explain: _____

I have not been diagnosed with any contraindications for colon irrigation. (See above*.)
I am aware that this colon irrigation and enema device facility has a Licensed Medical Director that is not on site.
I am aware adverse events such as perforation, injury and illness have been alleged and claimed with the use of colon irrigation and enema devices. Should I experience resistance during the nozzle insertion, I will immediately stop my session. If during the session I experience discomfort or pain, I am responsible for immediately stopping my session.
I am aware that Certified Therapists do not insert, diagnose, prescribe and do not cure or treat any condition or disease.

CLIENT SIGNATURE: **X** _____ Date ____/____/____
(For Clients 18 or under, the signature & attendance of the parent or guardian for insertion is required.)

I have reviewed this form with my client. Therapist Signature: **X** _____

Medical Director: **X** _____ Date ____/____/20__
Medical Director: Name Lic. # Phone

OR By Own Physician
Prescription Exp: _____