RIVERSTONE SPA & SHOPPE

Name_____ Date_____

Address_____ City_____ State_____Zip_____

Phone Cell _____ DOB_____ Age_____

Email Address_____

How did you hear about me? _____

Have you had colon hydrotherapy before?_____ Date_____
Results_____

What is your overall health goal?_____

What other therapies are you using?_____

FLUIDS

What is your total water intake per day in ounces?_____

Circle your main beverages: water: tap distilled OR other herb teas raw juices bottled juices coffee tea beer wine alcohol soft and diet drinks Do you have a juicer? Y N If yes, what kind?_____

Do you drink with meals? _____ What?_____
Quantity?_____

EXERCISE

What is your workout routine? Types of exercise_____

Length of workout?_____ Days Practiced _____

Circle: Does exercise come easy or hard? Did you have physical training as a child? Y N

DIET

Have you fasted? Y N Percentage of diet from fruits and vegetables?_____% Living foods_____%

Do you practice food combining? Y N Do you crave: sugar salt carbonation chocolate fat?

What percentage of the time do you eat out? _____% Order Out? _____%

EATING BEHAVIORS

Circle any behaviors you experienced: overeating bingeing anorexia bulimia bullimorexia late night eating eating when fatigued in pain constipated emotionally upset not hungry

Do you feel food addicted? Y N Do you eat slowly and chew well? Y N

Are you able to eat and drink what you intuitively feel is right for you? Y N

INTESTINAL HABITS

How often do you eliminate? Daily_____ Weekly_____

Initial any use. N= Now P= Past

Psyllium Bentonite Laxatives Enemas Colemas Enzymes Flora Stool Softener Antacids

Circle the appropriate. My bowel movements are:

Spontaneous occur only after eating effortless require straining painful incomplete

Do you have any family history of intestinal problems? Y N What?_____

SURGERIES

Circle and date operations: gall bladder uterus ovaries prostate intestines spleen C-section laparoscopy liposuction appendix tonsils rectocele cytocele back cyst tubal ligation vasectomy ectopic pregnancy Other_____

EMOTIONAL AND MENTAL STATUS

Circle any you experience excessively

Depression irritable codependent grief anger hurt sad forgetful anxious fearful despair victim of sexual or other abuse mental confusion obsessive compulsive bipolar suicidal

Are you under excessive stress? Y N How do you respond to stress? _____

MEDICATIONS

List herbs, vitamins, supplements used: _____

List over the counter medication used: _____
List prescription medication used: _____

Does any of your medication slow or speed your elimination? Name_____
Effect_____

INTESTINAL CONDITIONS

Initial any you experience. N= Now and P= Past

Fatigue after eating

Hungry all the time

Lactose intolerance

Indigestion

Gas

Bloat

Reflux/ heartburn

Constipation

Diarrhea

Diarrhea & Constipation

Atonic Colon

Gripping/ Cramping

Impaction

Hard Stool

Parasites

Black Stools

Intestinal/ Rectal bleeding

Prolapsus/ redundancy

Colitis/mucus /ulcerative diverticulosis

Spastic Colon

IBS

Celiac Disease

Crohn's Disease

Anal/rectal itching/ burning

Ulcer perforation

Fissure

Fistula

Hernias

Rectal Pain

Hemorrhoids

Colon/rectal carcinoma

Colon/rectal surgery

Other Conditions:

Bleeding Gums

Aneurysm

Earache

Headache

Migraine

Body odor

Auto-immune RX

Coated tongue

Chancre sores

Sinusitis

Asthma

Seizures

Chemical sensitivity

Allergies

Cancer

RA MS or arthritis

Candida

Fibromyalgia

CFS EBV

Lupus

Aids

Renal insufficiency

Psoriasis

Shingles

Herpes

Urination difficulties

Foot fungus

Skin itching/ rashes

Eczema

Hypoglycemia

Diabetes

Hepatitis

Nausea

Vomiting

Backache

Shoulder pain

Joint pain

Swollen prostate

Impotency

Parkinson's

Bell's Patsy

Stroke

insomnia

Heart disease

Varicosity

Hypothermia

Anemia

High triglycerides

High LDL's

High cholesterol

High blood pressure

Inability to lose weight

Water retention

Interstitial Cystitis

PMS

Irregular Period

Endometriosis

Uterine

Fibroids

Pregnancy

Abortion

Cysts

Menopause

STD

Infertility

Accident Injury or Trauma

Consent for Therapy and Waiver of Liability

The undersigned ("Client") hereby freely consents to receive colonic services from:

Riverstone Spa & Shoppe

Client agrees as follows:

Client understands and agrees that they will provide the Therapist with complete and accurate health information. It may be necessary to provide your therapist with a written referral from your primary healthcare provider. Client understands that colon hydrotherapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.

1. **Client and Therapist have discussed the potential benefits and possible side effects of colon hydrotherapy. Client has been given an opportunity to ask questions and discuss any concerns he or she may have.**

2. **Client understands that the semi-clothed body will be draped at all times for warmth, sense of security, and as a mark of professionalism. Client agrees to immediately inform the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to Client's level of comfort. Client understands that colon hydrotherapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client's behalf will result in an immediate termination of the therapy session. Client understands that payment will be expected in full; regardless if the procedure is completed or not.**

3. **Client hereby assumes fully responsibility for receipt of the colon hydrotherapy, and releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist, to the fullest extent allowed by law.**

4. **Client, in signing this consent for Therapy and Waiver of Liability ("Consent"), understands and agrees that this Consent will apply to and govern the current and all future therapy sessions performed by Therapist**

_____ _____

Client Signature **Client Printed Name**

_____

Date