

## Xu Wellness Center

235 Germantown Bend Cove

Cordova, TN 38018

Phone: (901) 737-8282

Fax: (901) 737-8239

[www.XuWellnessCenter.com](http://www.XuWellnessCenter.com)

### Colon Hydrotherapy Form

Name		Date	
Street Address		Sex	
City	State	Zip	Date of Birth
Mobile Phone & Provider	Marital Status	Height	Weight
Work Phone	Maiden/ Former Name		
Home Phone	Emergency Contact Name & Relationship to You		
Email	Emergency Contact Phone		
Under Physician's Care? What for?	Primary Physician		
Occupation	Employer		
Referred by	Other Family Members Seen Here		

### Contraindications

**\*Please carefully read over the conditions below, and check beside the box if any apply.**

<input type="checkbox"/> <b>Abdominal Surgery</b>	<input type="checkbox"/> <b>Abdominal Hernia</b>	<input type="checkbox"/> <b>Anemia</b>
<input type="checkbox"/> <b>Abnormal Distension</b>	<input type="checkbox"/> <b>Ulcerative Colitis</b>	<input type="checkbox"/> <b>Crohn's Disease</b>

<input type="checkbox"/> Hemorrhaging	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Diverticulitis/ Diverticulosis
<input type="checkbox"/> Hemorrhoidectomy	<input type="checkbox"/> Lupus	<input type="checkbox"/> Colitis
<input type="checkbox"/> Cardiac Condition	<input type="checkbox"/> Pregnancy- Due Date: _____	<input type="checkbox"/> Rectal/ Colon Surgery
<input type="checkbox"/> Fissures/Fistulas	<input type="checkbox"/> Dialysis Patient	<input type="checkbox"/> Intestinal Perforation
<input type="checkbox"/> Renal Insufficiencies	<input type="checkbox"/> Acute Liver Failure	<input type="checkbox"/> Cancer- Type: _____
<input type="checkbox"/> Taking Medications, which may weaken intestinal walls? _____		

### Health History

Please check if you have any of the following

<input type="checkbox"/> Allergic to Latex/ Other Allergies: _____	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Bloating
<input type="checkbox"/> BM Painful/ Difficult	<input type="checkbox"/> Burning/ Itching Anus	<input type="checkbox"/> Constipation/ Diarrhea
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Internal Hemorrhoids
<input type="checkbox"/> Rectal or Blood in Stool	<input type="checkbox"/> Recent Colonoscopy	<input type="checkbox"/> External Hemorrhoids
<input type="checkbox"/> Use Laxatives	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Date of Last Menstrual: _____
<input type="checkbox"/> Other Medical Condition: _____ _____ _____		

Have you recently taken any of the following? Please check the box

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Voltaren	<input type="checkbox"/> Aleve	<input type="checkbox"/> Advil
<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Indocin	<input type="checkbox"/> Naproxen	<input type="checkbox"/> Celebrex
<input type="checkbox"/> Dolobid	<input type="checkbox"/> Clinoril	<input type="checkbox"/> Orudis	<input type="checkbox"/> Relafin
<input type="checkbox"/> Feldine	<input type="checkbox"/> Tolectin	<input type="checkbox"/> Lodine	<input type="checkbox"/> Toradol
<input type="checkbox"/> Daypro	<input type="checkbox"/> Prednisone	<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Warfarin
<input type="checkbox"/> Digoxin	<input type="checkbox"/> Carvedilol	<input type="checkbox"/> Atorvastatin	<input type="checkbox"/> Coreg
<input type="checkbox"/> Lipitor	<input type="checkbox"/> Zocor	<input type="checkbox"/> Lescol	<input type="checkbox"/> Mevacor
<input type="checkbox"/> Pravachol	<input type="checkbox"/> Plavix	<input type="checkbox"/> Furosemide	<input type="checkbox"/> Narcotics
<input type="checkbox"/> Other Statin to Lower Cholesterol	<input type="checkbox"/> Other Diuretic		

Please list any other medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Informed Consent

I understand that I am financially responsible to Xu Wellness Center for payment at time service is rendered. I am aware that checks are not accepted for this service, and I must pay with cash or a credit/debit card. I authorize Xu Wellness Center to contact me at the above contact information.

I understand that I must cancel or reschedule my appointments with at least a 24-hour notice, or I will be charged the full service price (not the sale or discounted price). This includes no shows. If I have a package then any appointment canceled within 24-hours or any appointment not shown up for will be counted as a used session and will be forfeited. I agree to the before mentioned charge being applied to my credit card that is stored on file. All purchased Colon Hydrotherapy packages must be used within a year of original purchase date.

**I have not been diagnosed with any above-mentioned contraindications for colon irrigation/ colon hydrotherapy, or I have obtained a prescription from a physician to receive colon hydrotherapy. The above information is true to the best of my knowledge. I am aware that Xu Wellness Center may not always have a physician on site. I am aware adverse events such as perforation, injury, and illness have been alleged and claimed with the use colon irrigation and enema devices. Should I experience resistance during the nozzle insertion, I Will Immediately Stop My Session. I am aware that trained therapists do not insert, diagnose, prescribe, and do not cure or treat any condition or disease.**

**Possible Side Effects of Colon Hydrotherapy:** Increased Energy, Nausea, Vomiting, Cramping, Light Headedness, Excessive Gas or Bloating, Overheating, Diarrhea, Headaches, Temporary Increase in Body Odor, Joint or Body Aches, Increased Appetite, Hemorrhoids: *(which may be irritated, inflamed, or bleed)*

**Precautions:** Over Hydration: *(may occur when multiple colonic sessions are done during a short period of time)* Perforation of Rectum/ Colon, Irritation/ Inflammation/ Allergic Reactions of the rectum due to lubricant, water over temperature, other issues when colonic equipment is improperly used, not maintained properly or operated by untrained therapists.

**I understand that inappropriate behavior of a sexual or violent nature towards my therapist will not be tolerated!!! If I initiate any inappropriate behavior, my therapist will immediately end the session, and I will be responsible for the full price of service. If my behavior warrants police involvement, I am aware that they WILL BE CALLED!!!**

**I consent to receiving Colon Hydrotherapy at Xu Wellness Center, and I agree to abide with all terms and conditions before mentioned.**

**Client Signature** **X** \_\_\_\_\_

Print Name \_\_\_\_\_ **Date** \_\_\_\_\_

If under 18/ Guardian  
Signature \_\_\_\_\_

