Alternative Health Empowerment, Inc.

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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_____

In Pain?_____ Where?_____

***Contraindications: check and Date if you have ever had any of the following:**

DATE	DATE
____**Abdominal Hernia**	____**Diverticulosis/Diverticulitis**
____**Abdominal Surgery**	____**Fissures & Fistulas**
____**Abnormal Distension**	____**Hemorrhaging**
____**Acute Liver Failure**	____**Hemorrhoidectomy**
____**Anemia**	____**Intestinal Perforations**
____**Aneurysm – All Types**	____**Lupus**
____**Carcinoma of the Colon**	____**Pregnant –** (due date _____)
____**Cardiac Condition**	____**Rectal / Colon Surgery**
____**Crohns Disease**	____**Renal Insufficiencies**
____**Colitis**	____**Taking medications, which may weaken intestinal walls?**
____**Dialysis Patients**	

_____ 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 Menstrual Cycle
Other_____

If Any Checked, Please Explain:_____

_____

_____

I have not been diagnosed with any contraindications for colon irrigation. (See above*.)
I am aware that 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**_____

Medications: _____

_____

*Notes:*_____

_____

_____

_____

Other Notes: _____

_____

_____

_____

_____

Session Information:

#	Date	Therapist	Client Initials

Session Information:

#	Date	Therapist	Client Initials

ATTENTION: PREPAID SESSION PACKAGES ARE SOLD AS FOLLOWS:

1. All Prepaid Colonic procedures are to be used within 6 months of purchase.
2. No Show appointments are counted as a used session without a 12 hour advance cancellation.
3. Confidential Information should be updated after twelve sessions. Transferable, but no refunds!

CLIENT SIGNATURE: **X**_____ Date ____/____/____

(For Clients 18 or under, the signature & attendance of the parent or guardian for insertion is require