



AQUA
SANTÉ

CLIENT INTAKE FORM

Name _____ Date _____ Email _____
 Address _____ Emergency Contact _____ Phone _____
 Phone _____ Height _____ Weight _____ Date of Birth _____

Please answer the questions below:

How did you learn about us? _____

Have you received colon hydrotherapy before? Yes No

Are you on any medications? Yes No If yes, which ones: _____

Are you under a physician's care? Yes No Name of physician: _____ Type of care: _____

Please *Check* and *Date* any of the following contraindications:

Please *Check* any current contraindication:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abdominal Hernia _____ | <input type="checkbox"/> Diverticulosis/Diverticulitis _____ | <input type="checkbox"/> Hemorrhoids: Int__ / Ext __ |
| <input type="checkbox"/> Abdominal Surgery _____ | <input type="checkbox"/> Fibroids _____ | <input type="checkbox"/> Rectal Bleeding / Blood in Stool |
| <input type="checkbox"/> Abdominal Pain _____ | <input type="checkbox"/> Fissures & Fistulas _____ | <input type="checkbox"/> Recent Colonoscopy |
| <input type="checkbox"/> Abnormal Distension _____ | <input type="checkbox"/> Hemorrhaging _____ | <input type="checkbox"/> Use of Laxatives |
| <input type="checkbox"/> Acute Liver Failure _____ | <input type="checkbox"/> Hemorrhoidectomy _____ | <input type="checkbox"/> Painful or Difficult BM |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Intestinal Perforations _____ | <input type="checkbox"/> Burning or Itching Anus |
| <input type="checkbox"/> Aneurysm - All Types _____ | <input type="checkbox"/> Lupus _____ | <input type="checkbox"/> Constipation __ / Diarrhea __ |
| <input type="checkbox"/> Cancer: Type _____ | <input type="checkbox"/> Rectal / Colon Surgery _____ | <input type="checkbox"/> Vomiting __ / Bloating __ |
| <input type="checkbox"/> Cardiac Condition _____ | <input type="checkbox"/> Renal Insufficiencies _____ | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Colitis _____ | <input type="checkbox"/> Thyroid Conditions _____ | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Crohn's Disease _____ | <input type="checkbox"/> Pregnancy - Due Date _____ | <input type="checkbox"/> Latex or Lubricant Allergy |
| <input type="checkbox"/> Dialysis _____ | Date of Last Menstrual Cycle:
_____ | <input type="checkbox"/> Bladder Infection |
| | | <input type="checkbox"/> Other _____ |

I understand that the colon hydro-therapist does not diagnose illness, disease or any other physical / mental disorder and does not prescribe medical treatment nor pharmaceuticals. I will inform the therapist of my current condition at each visit. If I have a pre-existing condition or are following a prescribed treatment, a referral from my GP is required. It has been explained to me that colon therapy is not a cure or substitute for a medical examination, treatment or diagnosis and it is recommended that I see a physician for any ailments that I might have. All information that I provided is correct to the best of my knowledge. If any health issues arise, I agree to inform my therapist and physician. 24 hours notice is required for all cancellations and postponements. Payment in full is requested at the time of visit.

Date _____

Signature _____

Thank you for choosing Aqua Santé



AQUA
SANTÉ

DISCLOSURE & LIABILITY RELEASE FORM

SESSIONS

1. All prepaid, discounted Colonic Sessions are to be used within six (6) months of purchase.
2. No-show appointments are counted as a used session without a 12-hour advance cancellation.
3. Health history should be updated after twelve sessions.
4. No refunds, non-transferable.

POSSIBLE SIDE EFFECTS

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 become irritated, inflamed or may bleed).

CERTIFICATIONS

I am aware that adverse events, such as perforation, injury and illness have been alleged and claimed with the use of colon hydrotherapy, colon imaging and or enema systems. Should I experience resistance during my nozzle insertion, I will be responsible to immediately stopping my session. If during the session, I experience discomfort or pain, I am responsible for immediately stopping my session. I am aware that I will be inserting and retracting the speculum.

I have reviewed and discussed with the LIBBE Device-Trained Therapist that I do not have any diseases, contraindications or other health concerns and I wish to proceed with my colon hydrotherapy sessions.

Aqua Santé uses a USA Food & Drug Administration (FDA) Colon Hydrotherapy Device and the hydro-therapists using and operating Colonic Devices are required to have completed Manufacturer Device Training. Aqua Santé uses the FDA-approved LIBBE System and the trained hydro-therapists have completed system training as well as an I-ACT Certification Course. For more information, visit i-act.org.

I have read, understand and agree to the the above information and I release Aqua Santé from all liability.

Date _____

Client Signature _____

As a Trained Therapist, I have reviewed and discussed this form with the above client.

Date _____

Therapist Signature _____



CLIENT CONSULTATION FORM

Name

Date of Birth

Phone Number

Email

SESSIONS

1. Session Date:

Observations:

2. Session Date:

Observations:

3. Session Date:

Observations:

4. Session Date:

Observations:

5. Session Date:

Observations:

6. Session Date:

Observations:

7. Session Date:

Observations:

8. Session Date:

Observations:

9. Session Date:

Observations:

10. Session Date:

Observations:

11. Session Date:

Observations:

12. Session Date:

Observations: