AQUA SANTÉ

CLIENT INTAKE FORM

Name _____ Date _____ Email _____

Address _____ Emergency Contact _____

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 physcian: _____ Type of care: _____

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

- ☐ Abdominal Hernia _____
- ☐ Abdominal Surgery _____
- ☐ Abdominal Pain _____
- ☐ Abnormal Distension _____
- ☐ Acute Liver Failure _____
- ☐ Anemia _____
- ☐ Aneurysm - All Types _____
- ☐ Cancer: Type _____
- ☐ Cardiac Condition _____
- ☐ Colitis _____
- ☐ Crohn's Disease _____
- ☐ Dialysis _____
- ☐ Diverticulosis/Diverticulitis _____
- ☐ Fibroids _____
- ☐ Fissures & Fistulas _____
- ☐ Hemorrhaging _____
- ☐ Hemorrhoidectomy _____
- ☐ Intestinal Perforations _____
- ☐ Lupus _____
- ☐ Rectal / Colon Surgery _____
- ☐ Renal Insufficiencies _____
- ☐ Thyroid Conditions _____
- ☐ Pregnancy - Due Date_____
- Date of Last Menstrual Cycle: _____

Please *Check* any current contraindication:

- ☐ Hemorrhoids: Int__ / Ext __
- ☐ Rectal Bleeding / Blood in Stool
- ☐ Recent Colonoscopy
- ☐ Use of Laxatives
- ☐ Painful or Difficult BM
- ☐ Burning or Itching Anus
- ☐ Constipation __ / Diarrhea __
- ☐ Vomiting __ / Bloating __
- ☐ High Blood Pressure
- ☐ Infectious Disease
- ☐ Latex or Lubricant Allergy
- ☐ Bladder Infection
- ☐ 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 am 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** _____