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 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

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

Fatigue after eating Hungry all the time Lactose intolerance Indigestion

Gas Bloat

Reflux/ heartburn Constipation Diarrhea

Diarrhea & Constipation Atonic Colon

Gripping/ Cramping

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

Impaction Hard Stool Parasites Black Stools

Intestinal/ Rectal bleeding

Prolapsus/ redundancy

Colitis/mucus /ulcerative diverticulosis

Spastic Colon IBS

Celiac

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

Coated tongue

Chancre sores Sinusitis Asthma Seizures

Chemical sensitivity

Allergies Cancer

RA MS or arthritis

Candida Fibromyalgia CFS EBV

Lupus

Renal insufficiency

Psoriasis Shingles Herpes

Urination difficulties

Aids

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 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**

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**11570 Red Hibiscus Drive**

**Bonita Springs, Florida**

**34135**

[**Riverstonespanaples.com**](http://riverstonespanaples.com/)

**(239) 438-2611**

If you are doing your colon hydrotherapy session as part of a more in-depth cleanse, now is the time to begin it! The following preparation guide is intended to bring the most comfortable, relaxing, and thorough cleanse possible. We highly recommend placing this guide on your refrigerator to help remind you before your upcoming appointment.

**Preparing for your session**

We recommend 2-3 days prior to your session to do the following to get the best results:

* Avoid carbonated beverages. Drink plenty of water!
* Avoid gas-causing foods such as legumes, hummus, broccoli, raw kale, brussel sprouts, all nuts (immediately), cauliflower, corn, and cabbage.
* Avoid processed and rich foods such as: breads, sweets, and all dairy products (i.e. ice cream and cheese)
* Avoid all protein powders, shakes and bars (Immediately). Even plant-based protein can be quite constipating and because of this we do not recommend them, ever.

**In the 2 hours prior to your session…**

* It is best not to eat unless you have a medical condition that prevents you from fasting before your treatment.
* Do not drink any liquids, you can sip a little water if need be.

It is important to stop eating and drinking prior to your session because the session will include an abdominal massage, which is more comfortable on an empty stomach and bladder.

**Natural Remedies, Alternative Medicine Disclaimer**

The information shared, including information on natural remedies, homeopathy, and alternative medicine, is not intended, or implied to be a substitute for professional medical advice, diagnosis, or treatment; it is for informational and educational purposes only. We are not doctors and therefore do not diagnose, treat, or cure any specific health condition. Always seek the advice of your physician prior to starting any new regimen with any questions you may have regarding a medical condition. If you or any other person has a medical concern, you should consult with your health care provider or seek other professional medical treatment.