



RUBY ROOM[®]
the style of wellness[®]

colon hydrotherapy

NAME (last, first) _____ M F DOB ___/___/___

Have you ever had colon hydrotherapy? Y / N If yes, where and when? _____

Please list goals, complaints or symptoms that brought you here _____

Are you currently under a doctor's care for any illness or symptoms? Y / N

If yes, whom and for what? _____

Do you take laxatives or stool softeners? Y / N If yes, how often? _____

List all other supplements or medications you are currently taking _____

List any surgeries you have had _____

How many bowel movements do you have each day? _____ Do you strain? _____

Do you have hemorrhoids or anal fissures? _____

What do you wish to receive from your colon hydrotherapy session? _____

I understand that colon hydrotherapy is not a medical practice or a substitute for medical care. I further understand that the therapist administering the hydrotherapy session is not a licensed medical practitioner and therefore is not permitted to diagnose, prescribe or treat disease of any kind. I additionally verify that I have disclosed to the therapist prior to the session any contraindications to colon hydrotherapy that I may have. Contraindications include, but are not limited to: colitis, diverticulitis, fistulas, advanced pregnancy, colon cancer, blood in stool, bleeding from rectum, renal insufficiency, anemia, cirrhosis, hernia, severe abdominal pain.

Signature _____ Date _____