

Doctors Authorization for Colonics

To: _____

From: **Transitions**

461 7th Street West, Ste #5
 Phone # 707-938-4755
 Fax # 707-938-4745

Date: _____

Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____
 Age _____ Height _____ Weight _____ Birth Date _____

Have you been diagnosed with any serious condition or disease? _____
 Are you under the care of a doctor or health care professional? _____ If yes (who)? _____
 Have you had any surgery in the last 6 months? _____ How many colonics have you had? _____
 Are you taking any medications that would affect the integrity of the intestines? _____

CONTRAINDICATIONS	
Have you ever been diagnosed with any of the following: <input type="checkbox"/> Abdominal Hernia <input type="checkbox"/> Abdominal Surgery <input type="checkbox"/> Abnormal Distension <input type="checkbox"/> Acute Liver Failure <input type="checkbox"/> Severe Anemia <input type="checkbox"/> Aneurysm - All Types <input type="checkbox"/> Carcinoma of the Colon <input type="checkbox"/> Cardiac Disease <input type="checkbox"/> Chrohns Disease <input type="checkbox"/> Colitis <input type="checkbox"/> Dialysis Patients <input type="checkbox"/> Diverticulosis/Diverticulitis <input type="checkbox"/> Fissures & Fistulas <input type="checkbox"/> Hemorrhaging <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Intestinal Peforation <input type="checkbox"/> Lupus <input type="checkbox"/> Pregnant (1st / 3rd Trimester) <input type="checkbox"/> Recent colon Surgery (6 months) <input type="checkbox"/> Renal Insufficiencies <input type="checkbox"/> Uncontrolled Hypertension <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Severe Hemorrhoids <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Are you currently taking any medications which may weaken the intestinal walls? <input type="checkbox"/> Patient Initials	Please check if you currently have any of the following: <input type="checkbox"/> BM Painful/Difficult <input type="checkbox"/> Bladder Infection <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Burning/Itching Anus <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Recent Barium Enema <input type="checkbox"/> Recent Colonoscopy <input type="checkbox"/> Strain <input type="checkbox"/> Use of Laxitives <input type="checkbox"/> Vomiting <input type="checkbox"/> Hay Fever <input type="checkbox"/> Headaches <input type="checkbox"/> Increased Body Odor <input type="checkbox"/> Insomnia <input type="checkbox"/> Indigestion After Meal <input type="checkbox"/> Irritability <input type="checkbox"/> Lack of Vitality <input type="checkbox"/> Nausea <input type="checkbox"/> Overweight <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Protruding Abdomen <input type="checkbox"/> Skin Problems <input type="checkbox"/> Sour Stomach <input type="checkbox"/> Stool (very foul odor) <input type="checkbox"/> Underweight <input type="checkbox"/> Patient Initials

I hereby acknowledge and accept signing this doctor's authorization for colonics. Transitions has informed me that a medical doctor's prescription is needed on file in order to assist me with my next colon hydrotherapy session. This form is authorization to release my health information to the above doctor. I have never been diagnosed with any contraindications for colon irrigation (see above list.) I am aware the colon hydrotherapist is not a Physician and therefore do not insert, diagnose or prescribe. I am aware adverse events such as perforation, injury and illness have been alleged and claimed with the use of colon irrigation and enema devices. I am responsible for my own self-insertion. If I experience resistance during the insertion, or pain, I will immediately stop my session. This facility does not claim to cure or treat any condition or disease.

Client Signature: _____ Date: _____

THIS CLIENT IS AUTHORIZED TO HAVE COLONICS AS NEEDED

Doctor Signature: _____
 Date: _____