3850 Foothills Road, Suite 9
Las Cruces, NM 88011
(575) 520-5077

Aria Wellness

Colonic Intake Form

Name:_____Date:_____
Address:_____
City: _____State: _____Zip: _____Phone:_____
Email:_____Cell#:_____*Carrier:_____
Business/Occupation: _____ Referred by:_____
How did you hear about us:_____

HEALTH INFORMATION

Height: _____ Weight: _____Age: _____ Male: _____ Female: _____

Are you experiencing any of the following conditions? (Please check which you are currently experiencing).

Constipation: _____

Heartburn: _____

Overweight: _____

Bruise easily: _____

Bowel Gas: _____

Indigestion: _____

Cellulite: _____

Diarrhea: _____

Headaches: _____

Bloating: _____

Candida: _____

Acne: _____

Hemorrhoids: _____

Aching joints: _____

High stress: _____

Menstrual problems: _____

Poor concentration: _____

Allergies/Asthma: _____

Water retention: _____

Heart problems (please indicate).

_____

Health habits: How often do you use any of the following? D -daily O –occasionally R -rarely:

Laxatives_____ Cigarettes_____ Alcohol_____ Coffee_____ Sodas_____ Antacids_____ Aspirin/Motrin _____

Pain killers _____

Dietary habits: How often do you eat the following? **D –daily O- occasionally R – rarely:**
Meat _____ Dairy _____ Whole grains _____ Vegetables _____ Fruit_____

_____ Refined foods (white bread, white rice, pasta, cookies) _____ Sweets/desserts
_____ Fast Food _____ How many glasses of water do you drink daily? _____

Have you ever had colonics before? _____

Do you take vitamins, herbs or homeopathic medicines? Please specify.

_____

_____

_____

Do you take any medications? Please specify.

_____

_____

Number of bowel movements each day _____ a week _____

Have you been diagnosed with any of following?

Irritable bowel disorder _____

Irritable Bowel Syndrome (IBS) _____

Colitis: _____

Crohns Disease _____

Diverticulitis _____

Severe Hemorrhoids _____

Fissures _____

Colon Cancer _____

Are you pregnant? _____ If yes, How many weeks? _____

Have you had abdominal surgery within the past year? _____ If yes, please specify.

_____

_____

Please list any other surgeries you have had and dates.

_____

_____

Why did you come to see us today?

_____

_____

Thank you,

Aria Wellness and Staff

Patient Signature _____ Date _____

CONTRAINDICATIONS

If you are diagnosed with any of the following you will speak with your doctor and the Colon Hydro therapist further in detail to see if the treatment is safe for you. You would NOT be a candidate for colon hydrotherapy, unless authorized by your treating physician.

Diverticulitis Ulcerative Colitis Crohn's Disease
Severe Hemorrhoids Rectal or Intestinal Tumors Recent Radiation Therapy
Uncontrolled Hypertension
Congestive Heart Failure
Organic Valve Disease
Aneurysm Blood Clots
Severe Anemia GI Hemorrhage/Perforation
Cirrhosis of Liver Fissures
Fistulas Hiatal/Abdominal Hernia Recent Colon Caner Colon Surgery
Renal Insufficiency

- Pregnant women are also advised to only receive colon hydrotherapy during the second trimester of their pregnancy, under the direct supervision and advice from their physician.
- Professionally administered colon hydrotherapy is generally safe if you are free of the above cited conditions/contraindications.

DISCLAIMER

Every therapy, service and product described or presented at Aria Wellness is not a cure for any disease, ailment, or health condition. No medical claims are expressed or implied, either directly or indirectly, regarding the therapies, products, or services presented herein. We do not diagnose, treat, or prescribe any conditions/diseases. We are not licensed massage therapists, so we require permission to touch you if you desire. For services, such as a Foot Detox Spa, Foot Reflexology, and/or an abdominal massage during your colonic, we will require permission from each client. _____ **(Initials)**

As your therapist, we will start the colonic system for you, monitor your progress during the session, and stop the system for you upon completion of the session. _____ **(Initials)**

I agree that the above information is accurate to the best of my knowledge. I also, agree to inform the staff of any changes in my health, medical condition, and medications/supplements I am taking. _____ **(Initials)**

I give Aria Wellness and staff permission to evaluate (not diagnose, treat or prescribe) and provide colon hydrotherapy and other requested holistic alternative modalities. _____ **(Initials)**

I am aware of and do not have contraindications. _____ **(Initials)**

I have received a copy of Aria Wellness' Policies, as well as a list of the contraindications for colon hydrotherapy and I hereby agree that I am responsible for my health and the services received here. _____ **(Initials)**

CANCELLATION POLICY

As a courtesy to other clients and therapists, appointments must be cancelled 24 hours in advance. If not, you will be charged 50% of the fee for your appointment. No-shows will be charged in full.

_____

What if I arrive late?

Arriving to your appointment late will simply limit the time for your session. Your session will end on time so that the next client will not be delayed. If you arrive late it is up to you whether you prefer to receive a shortened session or pay for the appointment and reschedule.

Patient Signature _____ Date _____