HEALTH QUESTIONNAIRE & CONSENT FORM

Name_____ Male/Female/Other _____

Address _____

City _____State_____ Zip _____

Cell Phone: _____ Other Phone: _____ Email:_____

Referred by / How did you hear about us? :_____

Have you received a colonic before? Y / N (circle one)

Date: _____ Results: _____

Are you under a Medical Doctor's care? Y / N (circle one) Doctor's Name: _____

If yes, please explain: _____

How often do you have a bowel movement? _____

How many glasses of water do you drink per day? _____

Please mark "X" next to any current health challenges:

___Constipation
___GI hemorrhage/Perforation
___Renal Insufficiency
___Diarrhea
___Diabetes/Hypoglycemia
___Diverticulitis/Diverticulosis
___Hemorrhoids
___Crohn's Disease
___Fissures/Fistulas
___Indigestion
___Belching/Flatulence/Gas
___Gall Bladder/Gall Stones
___Cardiac condition
___Cysts/Fibroids/Tumors
___Allergies
___Prostate Problems
___Fungus/Yeast/Candida/Parasite
___Colon Cancer
___Carcinoma
___High/Low Blood Pressure
___Stroke
___Hepatitis/Liver Problems
___Abdominal Hernia
___Ulcers
___Dialysis Patient
___Psyche Disorders (depression)
___Colitis
___Acne/Psoriasis/Eczema
___Pregnancy

Any other medical conditions that we should know about? _____

With my signature below, I hereby agree to current & future colon hydrotherapy treatment(s) performed by Eva Arroyo (or another therapist under her supervision) with its associated risks. I have not been diagnosed with any contraindications for colon hydrotherapy and am aware that colon therapists are not physicians and do not diagnose or prescribe. Any instructions, recommendations, and services given to me are not considered medical treatments or prescriptions, and I have not been promised or guaranteed any cures or medical outcomes. I have discussed the risks and contradictions of the treatment with the therapist and understand it is my responsibility to educate myself about this treatment. If I experience any pain or discomfort, I am responsible for immediately notifying the therapist to pause or stop the session. I release Livingstream Wellness & Colonics, Evelyn Arroyo (or attending therapist) from all liability, demands, claims, actions, loss, costs, risk, or compensation for any direct, indirect or incidental outcomes resulting from this treatment.

CANCELLATION / NO SHOW POLICY: The facility taking payment (Livingstream Wellness and Colonics) reserves the right to charge your credit card up to the FULL amount of the Colonic session ($135) if you NO SHOW without notification of cancellation at least 24-hours in advance. I greatly appreciate your understanding that therapists are committed to serving your needs at the designated time but may suffer avoidable financial loss when appointments are not kept without proper notification. I acknowledge this cancellation/no-show policy by signing below.

Evelyn Arroyo: Florida MA#54694, #MM45098

Signature: _____ Date: _____