RAINDROP
COLON HYDROTHERAPY

7921 Clayton Rd.
St. Louis, MO 63117
314.335.0395

CONTRAINDICATIONS FOR COLON HYDROTHERAPY

- Severe cardiac disease; e.g. uncontrolled hypertension
- Congestive heart failure or organic valve disease
- Aneurysm
- Severe anemia
- GI hemorrhage/perforation
- Rectal bleeding
- Severe ulcerative colitis
- Cirrhosis
- Carcinoma of the colon or rectum
- Fissures/Fistulas
- Pregnancy
- Abdominal hernia
- Recent colon or rectal surgery (1 year or less)
- Recent abdominal surgery (6 months or less)
- Recent colonoscopy (6 months or less)
- Renal insufficiency
- Diabetes
- Advanced Crohn's
- Advanced ileitis
- Epilepsy
- Diverticulitis
- Dementia
- Alzheimers
- Agent Orange exposure
- Abortion less than 6 months ago
- Miscarriage less than 4 months ago
- AIDS
- Psychosis

If you have any of the above listed conditions, colon hydrotherapy **cannot** be done.

Please initial that you have reviewed the contraindication list.

Name: _____ Initials: _____ Date _____/_____/_____

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INFORMED CONSENT

Neither Raindrop Colon Hydrotherapy or their associates do the following, either implied or intended:

1. We do not diagnose.
2. We make no attempt to cure any condition.
3. We make no claims or imply any claims that suggestions are given to cure any condition.
4. We do not claim that any supplemental material we speak about will cure any condition, or that its purpose is to treat any condition.
5. We do not prescribe or treat disease, however, we do attempt to educate you in/on foods and a good diet and exercise if it is not contradictory to the recommendations of your primary health care provider or physician.

I, the undersigned client, understand the above statements. I, as the client, understand that diet and nutrition are considered to be an inexact science and that the results obtained are not always constant or predictable. I also understand that there is no guarantee of any results and the opposite of the desired may appear. Whether or not I participate in the procedure or program is my decision, based on my constitutional rights of the Ninth Amendment. All decisions relative to my well being and health must be made by me. I further understand that Raindrop Colon Hydrotherapy is not a medical facility and is not attempting to portray themselves or conduct the activities of medical doctors. I also understand that the medical device used in this procedure is intended for the use of Colon Irrigation, and that these devices are intended for colon cleansing when medically indicated, such as before radiological or endoscopic examinations.

All results are contributive to research and utilization in future programs of while preserving my privacy, and I waive liability on behalf of the technician serving me.

SERVICE DISCLAIMER: Colon Hydrotherapy is not intended to diagnose, treat, cure or prevent any disease. Colon Hydrotherapy services are not supervised or performed by a physician. Colon Hydrotherapy services at Raindrop Colon Hydrotherapy are performed by a technician certified by the International Association of Colon Hydrotherapy. Raindrop Colon Hydrotherapy's technicians are not required to be licensed and are not regulated by the State of Missouri or other state or federal governmental agency. Raindrop Colon Hydrotherapy will not perform colon hydrotherapy if certain medical conditions or symptoms are present. Raindrop Colon Hydrotherapy is not intended to provide medical advice or to be a substitute for a visit to your doctor. Registration at Raindrop Colon Hydrotherapy does not create a doctor-patient relationship.

Signature: _____ Date _____/_____/_____

Print Name: _____

Address: _____

City/State/ZIP: _____

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Name: _____ Date: _____

Address: _____City: _____State: _____ZIP: _____

Do we have permission to send mailers to this address? ☐ YES ☐ NO

Email address: _____

Home phone: _____ Work phone: _____

Mobile phone: _____

Do we have permission to contact you at these numbers? ☐ YES ☐ NO

Birthdate: _____ Age: _____ Sex: ☐ M ☐ F

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Referred by: _____

PRICING

ALL FEES ARE TO BE PAID IN FULL AT THE TIME OF SERVICE. ONLY CASH AND CREDIT CARDS ARE ACCEPTED.

Single session:	$115		
Package of 3:	$320	(6 month expiration)	Additives are optional
Package of 6:	$600	(6 month expiration)	for additional cost.

CANCELLATION/REFUND POLICY

Please note the following policy is in place as a courtesy to myself, as I work by appointment only, but more importantly, to other clients who may be on a waiting list and very eager to obtain any availability.

All clients are required to give at least a 24-hour notice prior to any appointment cancellation. Any appointments that are canceled with less than a 24-hour notice will be charged a cancellation fee of $50. Clients that do not show up for their scheduled appointments will be charged the full fee of $115 or have one colonic deducted from his/her package.

IF THE CLIENT IS MORE THAN 15 MINUTES LATE TO AN APPOINTMENT, THEY WILL NEED TO RESCHEDULE AND WILL BE CHARGED A FEE OF $50.

Client Signature: _____ Date: _____

MEDICAL HISTORY

Client's Name: _____

Have you had colon hydrotherapy before? ☐ Yes ☐ No If yes, where? _____

Your primary reason for using this service? _____

_____

Do you use any of the following on a daily basis?

			How many?	
Alcohol	☐ Yes	☐ No	_____	Supplements: _____
Tobacco	☐ Yes	☐ No	_____	Vitamins: _____
Coffee	☐ Yes	☐ No	_____	Minerals: _____
Tea	☐ Yes	☐ No	_____	Herbs: _____
Soda	☐ Yes	☐ No	_____	
Water	☐ Yes	☐ No	_____	

Please mark any of the following symptoms you are experiencing and give a brief explanation.

Fatigue _____ Headaches _____ Bloating _____

Sugar cravings _____ Constipation _____ Skin issues _____

Poor immunity _____ Stress _____Dehydration _____

Autoimmune disease _____

Do you have any pain/inflammatioin in the following areas?

Neck: ☐ left side ☐ right side Shoulder ☐ Yes ☐ No

Jaw: ☐ Yes ☐ No Lower Back: ☐ Yes ☐ No

Describe your diet: _____

Over the counter medications: _____

Prescription medications (and prescribing doctor): _____

_____

Most recent medical service and/or hospitalization: _____

_____

Indicate if you have any medical problems and/or surgeries with the following. If so, please explain.

General symptoms: _____

Eyes, Ears, Nose & Throat: _____

Skin: _____

Allergies / Food sensitivities: _____

Respiratory: _____

Cardiovascular: _____

Muscle, Bone, Joint: _____

Thyroid: _____

Gall bladder: _____

Urinary/bladder/kidney: _____

Gastrointestinal: _____

Other medical history we should be aware of. Does anything run in your family? : _____

_____

MEDICAL HISTORY

Client's Name: _____

How frequently do you have a bowel movement?_____

Do you strain? ☐ Yes ☐ No Do you use laxatives? ☐ Yes ☐ No Brand: _____

Do you have hemorrhoids? ☐ Yes ☐ No Rectal bleeding? ☐ Yes ☐ No

Irritable bowels? ☐ Yes ☐ No Recent barium enema? ☐ Yes ☐ No

Colonoscopy? ☐ Yes ☐ No When and results? _____

Colon/Rectal surgery? ☐ Yes ☐ No How recent? _____

For women only: Painful menstruation: ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No Date of last period: _____

Do you plan to become pregnant in the near future?

Please advise your therapist if you are breastfeeding.

ADDITIONAL NOTES FOR YOUR THERAPIST:

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FOR OFFICE USE ONLY:

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