

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Email _____

Height _____ Weight _____ Birthdate _____ Referred By _____

Are you currently under a doctor's care? YES NO Explain: _____

Doctor's Name _____ Telephone _____

List all surgeries/dates _____

List all medications including OTC _____

The following conditions are contraindications for colon hydrotherapy unless under the supervision of a doctor

Have you ever been diagnosed with any of the following? If so, please explain in writing on the back of the form.

- | | | | |
|---|-----------------------------------|---|--|
| <input type="checkbox"/> Aneurysm/Blood Clot | <input type="checkbox"/> Colitis | <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Colorectal Cancer |
| <input type="checkbox"/> Cirrhosis of Liver | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Kidney disease/dialysis |
| <input type="checkbox"/> Bleeding Hemorrhoids | <input type="checkbox"/> Fissure | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Recent Abdominal Surgery,
i.e. |
| <input type="checkbox"/> GI Hemorrhage | <input type="checkbox"/> Crohn's | <input type="checkbox"/> Diverticulitis | gall bladder/appendix/prostate
removal |
| <input type="checkbox"/> Abdominal Hernia | <input type="checkbox"/> Fistula | <input type="checkbox"/> Rectocele | C-section, hysterectomy, etc. |

ARE YOU PREGNANT? IF SO, NO COLON HYDROTHERAPY

Please put an "X" beside anything that is currently a health challenge. Put a "p" beside a past problem.

- | | | | |
|------------------------|-------------------------|-----------------------|--------------------------------|
| _____ Acid reflux | _____ birth control/HRT | _____ flatulence/gas | _____ mental disorder |
| _____ acne | _____ brain fog | _____ headaches | _____ mood disorder |
| _____ allergies | _____ breast implants | _____ hemorrhoids | _____ multiple sensitivities |
| _____ anemia | _____ cancer | _____ hepatitis TYPE? | _____ multiple sclerosis |
| _____ anorexia/bulimia | _____ celiac disease | _____ herpes I or II | _____ neurological
symptoms |

_____ antibiotics	_____ constipation	_____ hiatal hernia	_____ prostatitis
_____ arthritis	_____ cysts/tumors	_____ hairloss/growth	_____ sinus problems
_____ asthma	_____ diabetes	_____ infections	_____ swollen glands
_____ autism	_____ diarrhea	_____ insomnia	_____ ulcers
_____ auto immune	_____ dizziness	_____ irritability	_____ vision/hearing impairment
_____ backache	_____ fatigue	_____ menstrual difficulties	_____ Water retention

How often do you have a bowel movement? _____ What time of day? _____
 Are they spontaneous? _____ Only after eating? _____ Requires straining? _____ Effortless? _____
 Do you have hemorrhoids or other rectal problems? _____
 How often do you use a laxative? _____ Herbal laxative? _____ Stool softener? _____
 Suppositories? _____ Enemas? _____
 Have you ever had rectal bleeding? _____ If so, when? _____

Mark Y for yes and N for no. If yes, please list amount and frequency.

_____ Coffee _____	_____ diet programs _____
_____ tea _____	_____ vegetarian/vegan _____
_____ carbonated drinks/sparkling water _____	_____ exercise _____
_____ alcohol _____	_____ hours sleeping _____
_____ tobacco _____	_____ stress management _____
_____ sugar/salt cravings _____	_____ dairy products _____
_____ plain water intake per day _____	_____ source of water _____

How many mercury fillings do you have in your teeth? _____ How many root canals? _____

What do you hope to achieve from this appointment? _____

I acknowledge COYLE INSTITUTE is licensed through the State of Florida to perform colonics. The colon hydrotherapist is not a medical provider and does not diagnose nor prescribe. I am voluntarily requesting services.

Signature: _____ Date: _____

FULL CHARGE WITHOUT 24 HOUR NOTICE TO CHANGE APPOINTMENT. THANK YOU.

WAIVER, RELEASE, EXPRESS ASSUMPTION OF RISK AND INDEMNITY AGREEMENT

COYLE INSTITUTE COLON HYDROTHERAPY AND ITS AGENTS, PRINCIPALS, HYDROTHERAPIST AND EMPLOYEE HOLD YOUR SAFETY AS ITS PRIMARY CONCERN. HOWEVER, THE UNDERSIGNED UNDERSTANDS THAT COLON HYDROTHERAPY (THE "THERAPY ACTIVITIES") MAY BE DANGEROUS BY ITS NATURE, AND INJURY, SERIOUS INJURY, PERMANENT INJURY OR DEATH MAY RESULT. THE UNDERSIGNED IS VOLUNTARILY CHOOSING TO ACCEPT SUCH RISKS WITH FULL KNOWLEDGE OF THE RISKS AND DANGERS INVOLVED. THE UNDERSIGNED IS AWARE AND AGREES THAT BY EXECUTING THIS WAIVER, THE UNDERSIGNED IS GIVING UP THE RIGHT TO BRING LEGAL ACTION OR ASSERT A CLAIM AGAINST COYLE INSTITUTE.

Because massage and colonic therapies can be subject to substantial risk as described above, COYLE INSTITUTE urges all participants to obtain a physical examination from a licensed physician before participating in any of the Therapy Activities. The undersigned agrees that by participating in the Therapy Activities, THEY DO SO ENTIRELY AT YOUR OWN RISK. Any recommendation by the COYLE INSTITUTE COLON HYDROTHERAPY for changes in diet, including the use of food supplements, weight reduction and/or body enhancement products are entirely your responsibility, and the undersigned should consult a licensed physician prior to undergoing any dietary or food supplement changes. The undersigned agrees that they are voluntarily participating in these Therapy Activities and assumes all risks of injury, illness, pain, disfigurement or death.

In acknowledging that the undersigned is aware of and willing to assume the risks associated with these Therapy Activities, the undersigned hereby voluntarily agrees to waive, hold harmless and indemnify COYLE INSTITUTE COLON HYDROTHERAPY from any claims, demands, damages and causes of action of any nature whatsoever arising out of the Therapy Activities wherever performed, whether or not caused by the active negligence or fault, passive negligence or fault, or sole negligence or fault of Colon Hydrotherapist, whether during the performance of the Therapy Activities or thereafter, which the undersigned, their heirs, assigns or successors may have against COYLE INSTITUTE COLON HYDROTHERAPY for, on account of, or by reason of the undersigned's voluntary participation in the Therapy Activities and related activities associated with the Therapy Activities.

The undersigned assumes any and all risks of serious or minor injury, death, loss or damage to the person or property of the undersigned, and agrees to defend, indemnify and hold harmless COYLE INSTITUTE COLON HYDROTHERAPY (including any attorney's fees and costs incurred by COYLE INSTITUTE COLON HYDROTHERAPY), whether or not caused by the active negligence or fault, passive negligence or fault, or sole negligence or fault of Colon Hydrotherapist, whether or not the undersigned is actively engaged in the Therapy Activities or arising thereafter as a result of or related to the Therapy Activities.

The undersigned understands the content of this waiver and has executed this informed consent and waiver of claim of the undersigned's own free will and accord and in consideration of the fee paid to COYLE INSTITUTE COLOR HYDROTHERAPY to participate in Therapy Activities and further agree that no oral representation, statements, or inducements a part from the foregoing have been made. The undersigned has read and understands this entire documenta and the risk. The undersigned verifies that all the information provided to COYLE INSTITUTE COLON HYDROTHERAPY is accurate/true to the best of the undersigned's knowledge and belief. The undersigned represents that the undersigned has the necessary physical condition and information to participate in the Therapy Activities.

The undersigned expressly agrees that the agreement is intended to be as broad and inclusive as permitted by the law of the State of Florida. portion of this release from liability shall be deemed by a court of competent jurisdiction to be invalid, then the remainder of this release from liability shall remain in full force and effect and the offending provision or provisions severed here from.

The undersigned acknowledges that they have completely and honestly filled out the Health Intake Form attached and made a part hereto. The undersigned acknowledges that COYLE INSTITUTE COLON HYDROTHERAPY will rely, in part, on the information contained therein in providing the Therapy Activities. Failure to completely and honestly complete the Health Intake Form may result in unintended consequences, including serious or minor injury, death, loss or damage to the person or property of the undersigned.

COYLE INSTITUTE COLON HYDROTHERAPY do not claim to "cure" diseases, but simply help you make physical and mental choices in order to help your body heal itself. COYLE INSTITUTE COLON HYDROTHERAPY does not diagnose any disease, nor attempt to treat or prevent any disease or condition. For any products and/or services purchased from COYLE INSTITUTE COLON HYDROTHERAPY you should carefully read all product packaging and instructions. The products and services made available by COYLE INSTITUTE COLON HYDROTHERAPY have not been evaluated by the Food and Drug Administration. The Therapy Activities are not intended to be a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding any medical condition.

Date: _____ Sign: _____ Print: _____