

For Best Results

NOTE: If this is your first time doing a colon cleanse, you should prepare by drinking 64 ounces of water the day before and not eating any solid foods 2 hours before the scheduled start time the day of the procedure.

1. **Buy a high quality Probiotic** while at the Abundant Living Wellness Center today.

We carry therapeutic strength probiotics, enzymes, and digestive care products. Approximately 80% of your immune system exists in your gut. Having a healthy, balanced gut flora or microbiome is not only essential for proper immune function, but also impacts bowel regularity and overall health. A 30-day supply is available for \$20.00.

We carry a **40 Billion probiotic** that contains the most important strains of good bacteria that populate the large and small intestines (*Lactobacillus acidophilus* and *Bifidobacterium lactis*). The formulation is also designed to survive the transit through the highly acidic environment of the stomach in order to reach both the small and large intestines. Everyone should take a probiotic, especially those over 50, those who eat meat, dairy, fish, and anyone who has taken an antibiotic or had surgery.

2. Buy a really good **digestive enzyme** to promote a healthy intestinal lining, enhance digestion and nutrient absorption. ***If you have gastritis, then you should not take digestive enzymes.***

3. Gradually increase your consumption of whole grains (brown rice or quinoa are widely available) while decreasing your dairy, meat, refined grains, and fish intake.

4. Attempt to get at least 2 grams of Omega 3-6-9 oils daily from an algae-based source especially if you are not regular.

WHAT TO EXPECT AFTERWARDS

1. You can eat immediately after your cleanse; **however, for the next 4 hours, do not eat, a) red meat, b) white starches, or c) dairy products.**

2. **Schedule your follow-up cleanse within 14 days** of your initial visit to maximize the cleanse. It can be as soon as the second day after your first cleanse.

3. The earliest you will have another well-formed movement will be the following morning; **however, most will not have another movement for 2-4 days, if not regular before the initial cleanse.**

4. You are able to resume normal activity after your cleanse at the Nile Wellness Center because with the newer devices we use, we are able to ensure that the water is out of your system, which allows you to continue through the remainder of your day.

Dr. Kemi is a Board-Certified Naturopathic Doctor by the American Naturopathic Medication Association. We are not MDs, as such we do not diagnose or prescribe. She is a member of the American Naturopathic Medical Association

Text us at 404 406 8277 for apt of your next visit

Date _____
First Name: _____ M.I. ___ Last Name: _____
Email: _____
Mobile number: _____
Emergency contact number: _____
How did you hear of us? _____
Height: _____
Weight: _____
D.O.B. _____

Why have you chosen to have this procedure at this time?

I HAVE NOT BEEN DIAGNOSED WITH ANY CONTRAINDICATION FOR COLON IRRIGATION (SEE THE LIST ABOVE). I AM AWARE THAT COLON HYGIENISTS ARE NOT MEDICAL DOCTORS AND THEREFORE DO NOT INSERT, DIAGNOSE, OR

<input type="checkbox"/> abdominal hernia	<input type="checkbox"/> abdominal surgery	<input type="checkbox"/> abdominal distention
<input type="checkbox"/> acute liver failure	<input type="checkbox"/> aneurysm (all types)	<input type="checkbox"/> weight loss surgery
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> colitis	<input type="checkbox"/> colon carcinoma
<input type="checkbox"/> diverticulosis	<input type="checkbox"/> diverticulitis	<input type="checkbox"/> dialysis
<input type="checkbox"/> fistula	<input type="checkbox"/> Hemorrhoidectomy	<input type="checkbox"/> intestinal perforations
<input type="checkbox"/> lupus	<input type="checkbox"/> currently pregnant	<input type="checkbox"/> renal insufficiencies
<input type="checkbox"/> cosmetic surgery		

If any of these conditions have ever occurred, contact us at 770-454-1363.
CONTRAINDICATIONS: HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE ABOVE?

PRESCRIBE. I AM AWARE ADVERSE EVENTS SUCH AS PERFORATION, INJURY, AND ILLNESS HAVE OCCURRED WITH THE USE OF COLON HYDROTHERAPY AND ENEMA DEVICES. I AM RESPONSIBLE FOR MY OWN SELF-INSERTION. IF I EXPERIENCE RESISTANCE DURING INSERTION OR PAIN. I AM RESPONSIBLE FOR IMMEDIATELY STOPPING MY SESSION AND NOTIFYING THE STAFF.

Signature: _____

Informed Consent

Please check any of the following you have recently experienced		
<input type="checkbox"/> Abdominal hernia	<input type="checkbox"/> bladder infection	<input type="checkbox"/> blood in stool
<input type="checkbox"/> burning / itching anus	<input type="checkbox"/> heart trouble	<input type="checkbox"/> high blood pressure
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> rectal bleeding	<input type="checkbox"/> recent barium enema
<input type="checkbox"/> recent colonoscopy	<input type="checkbox"/> vomiting	<input type="checkbox"/> laxatives

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How often do you have bowel movements?

several daily Once daily Every 2-3 days Twice weekly Once per week

Are your movements at a consistent time of day when you have a movement(s)?

Always Sometimes Never

Must you use a laxative to have a bowel movement?

Never Sometimes Always

Must you generally strain to complete a bowel movement?

Never Sometimes Cannot pass without straining

Have you ever done this type of colon cleansing procedure before?

Yes (how long ago) _____

No (it's my first such procedure)

Circle any other conditions (HIV, AIDS, Hepatitis A, B, or C)

Are you currently under the care of a physician? YES NO

Have you had any surgical procedure within the past 12 months? YES NO

I, the undersigned, am in full agreement that colon cleansing is not a proven method, cure, or treatment of disease or condition, nor has it been portrayed as such. Colon cleansing in this facility is a self-administered procedure where, I as the user of the device, am solely responsible for my own actions and release liability regarding my health issues. The devices being used in this facility are **FDA registered Class I gravity devices** that can be used prior to endoscopic procedures. The facility I have chosen to visit is aware of the laws governing this facility at the time I sign this waiver of consent and that at any time those laws can change and neither I, my family, nor my representative(s) responsible for my personal choice to receive colon cleansing at this facility nor hold them liable for any changes or variations of the law after the time of my dated signature below. All results of my sessions are contributive to research and the utilization in future programs of self-health aid, while preserving my privacy, and waive any liability on behalf of the technician serving me.

General Health Information (check only if this is an ongoing issue for you)

<input type="checkbox"/> frequent urination	<input type="checkbox"/> excessive hunger	<input type="checkbox"/> gall bladder trouble	<input type="checkbox"/> difficult breathing
<input type="checkbox"/> acne	<input type="checkbox"/> allergies	<input type="checkbox"/> belching gas	<input type="checkbox"/> blood in urine
<input type="checkbox"/> constipation	<input type="checkbox"/> depression	<input type="checkbox"/> chest pain	<input type="checkbox"/> chills
<input type="checkbox"/> dry skin	<input type="checkbox"/> jaundice	<input type="checkbox"/> diarrhea	<input type="checkbox"/> fever
<input type="checkbox"/> itching	<input type="checkbox"/> overweight	<input type="checkbox"/> fainting	<input type="checkbox"/> insomnia
<input type="checkbox"/> nausea	<input type="checkbox"/> skin eruptions	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> liver trouble
<input type="checkbox"/> poor appetite	<input type="checkbox"/> sweats	<input type="checkbox"/> kidney trouble	<input type="checkbox"/> parasites

HABITS

How many hours of **SLEEP** do you get nightly (on average) ____

How many days a week do you **EXERCISE**? ____

How many glasses of **WATER** do you drink daily? ____

How many serving of fruits do you eat daily? ____

How many servings of whole grains do you eat daily? ____

Do you consume any of the following daily? ____ Alcohol ____ Coffee ____ Tea ____ Soft drinks

Do you take any of these on a daily basis? ____ Multivitamins ____ Supplements ____ Herbs








____ Probiotics ____ Digestive Enzymes

IS YOUR TOP WELLNESS GOAL AT THIS TIME? _____

Please **circle** any of the following prescription drugs you are taking below.

- | | |
|------------------------|---------------------------|
| Celexa (citalopram) | Heparin |
| Lexapro (escitalopram) | Warfarin |
| Prozac (fluoxetine) | Clopidrogel |
| Luvox (fluvoxamine) | Naproxen (Aleve) |
| Paxil (paroxetine) | Aspirin (Bayer, Bufferin, |
| Zoloft (sertraline) | Excedrin) |
| Relaphen | Ibuprofen (Advil, Motrin |
| Feldene | IB) |

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

Please circle one or more