

Cornerstone Therapeutics  
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Thank you for your recent inquiry about Colon Hydrotherapy. I am an I-ACT Certified Colon Hydro Therapist and Instructor with eighteen years of experience in the profession and also a Licensed Massage Therapist. Cornerstone offers hygienic and comfortable Colon Hydrotherapy, using disposable equipment and multi-filtered water. The use of a FDA cleared; self-sanitizing system allows the temperature and pressure to be regulated while maintaining maximum safety.

Colon Hydrotherapy is a safe, effective method of removing waste from the large intestine, without the use of drugs. By gently introducing filtered and temperature-regulated water into the colon, the waste is softened and loosened, resulting in evacuation through natural peristalsis. This process is repeated a few times during a session.

Fees:            First time session is 90 minutes - \$100  
                    One-hour session - \$75  
                    One-hour Senior Citizen - \$60  
                    Full-Time Student - \$60  
                    Thirty-minute consultation - \$40  
                    Massage Therapy One-hour session \$65.00  
                    Massage Therapy 90 Minute session \$90.00

Office Policies: Payment is due in full at the time of your visit. We accept cash, personal checks and credit cards. If a check is not sufficiently funded a returned check fee of \$35.00 will be billed to you.

Please be on time for your appointment, a shortened session will be charged at the full rate. A 24-hour notice is expected in the event of cancellation or postponement, otherwise a fee of \$40 will be charged.

For a healthy environment please refrain from wearing fragrances, colognes, flower oils, perfumed products or strong deodorants.

A referral from your primary health care provider is needed if you have an acute condition or are following a prescribed treatment.

Weekday and Saturday appointments are available. Please call Cornerstone at 781-775-7352 to schedule your appointment. I will be glad to answer any questions you may have.

Thank you,

*Lila Reader*

I-ACT is the International Association for Colon Therapy at [i-act.org](http://i-act.org).

## **What Is Colon Hydrotherapy?**

Colon Hydrotherapy is a safe, effective method of removing waste from the large intestine, without the use of drugs. By introducing filtered and temperature-regulated water into the colon, the waste is softened and loosened, resulting in evacuation through natural peristalsis. This process is repeated a few times during a session.

## **Equipment and Sanitation**

Modern Colon Hydrotherapy equipment is manufactured through compliance with FDA guidelines that dictate rigorous accountability. Our FDA-registered equipment features temperature controlled water, mixing and back flow prevention valves, pressure and temperature sensors, and a built-in chemical sanitizing unit. Filtered water and disposable single-use speculae are used.

## **Consider Preparation for your Colon Hydrotherapy Session.**

Prior to your session it is helpful to begin the cleansing process by considering what kind of nutrition, hydration and exercise habits you have. Some basic choices to enhance your experience are to eat fresh organic fruits, vegetables, and grains and hydration. Eat slowly and chew your food for better digestion.

On the day of your appointment eat lightly and limit your water intake. Avoid any foods or beverages that cause you digestive discomfort such as dairy products, fatty foods, junk food and gas producing foods such as beans, broccoli and carbonated beverages.

## **When you arrive for your Session.**

A session is a comfortable experience for many people. You will be given a brief review of the equipment and how to get ready. You will be asked to visit the restroom to empty your bladder and change from the waist down with a large towel to cover you. On the therapy table the disposable speculum will be self-inserted approximately two inches into the rectum. The speculum will have two outer tubes attached, an inflow tube, which infuses a small amount of water into the colon gently stimulating it's natural peristaltic action to release softened waste, and the outflow tube where the waste material and water is expelled.

## **What to expect after your Session.**

At the close of your session you will use the bathroom. The results leave you feeling empty and relaxed. Depending on your toileting habits it may be 1-3 days before your next bowel movement. The Colon Hydrotherapy you experienced will have taught you more about your own body's mechanics and the removal of waste may encourage better colon function and elimination.

The number of Colon Hydrotherapy sessions desired will depend on the individual. Every person's goals will differ. Just as some people exercise on a daily or weekly basis to tone and tighten their outer body; some people follow an ongoing cleansing, toning and rebuilding regimen for the inner body. Colon hydrotherapy could be used as part of any regular maintenance program.

## Cornerstone Therapeutics

Please help us provide you with the most appropriate and effective service by completing the following questions. All information is kept confidential. **(Please print clearly on front and back.)**

Today's Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ E-mail \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Gender: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Is this your first Colon Hydrotherapy session? Yes \_\_\_\_ No \_\_\_\_ . If not, when and where was your most recent visit? \_\_\_\_\_

What, if any, is your prior experience with colon cleansing, other than colon hydrotherapy?

Enemas \_\_\_\_ Fasting \_\_\_\_ Juicing \_\_\_\_ Herbs \_\_\_\_ Laxatives \_\_\_\_ Other \_\_\_\_\_

Your goal for colon hydrotherapy is: \_\_\_\_\_

List any Intestinal-related procedures you have had:

\_\_\_\_ Colonoscopy \_\_\_\_ Sigmoidoscopy \_\_\_\_ Barium Enema \_\_\_\_ Surgery \_\_\_\_ Other

Have you had any surgery within the last year? Please Describe: \_\_\_\_\_

Health History: Do you currently have, or have you had in the past, any of the following:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Reproductive Problems |
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Hemorrhoids         | <input type="checkbox"/> Sinus Problems        |
| <input type="checkbox"/> Anorexia/Bulimia            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Skin Condition        |
| <input type="checkbox"/> Appendicitis                | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Ulcer                 |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Abdominal Gas/Pain    |
| <input type="checkbox"/> Auto Immune Disease         | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Bad Breath            |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Belching              |
| <input type="checkbox"/> Candida Albicans            | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Bloating              |
| <input type="checkbox"/> Circulatory Condition       | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Blood in Stool        |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Anal Discomfort       |
| <input type="checkbox"/> Dizziness/Fainting          | <input type="checkbox"/> Kidney Stones       | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Epilepsy/Seizures           | <input type="checkbox"/> Liver Imbalance     | <input type="checkbox"/> Chron's Disease       |
| <input type="checkbox"/> Edema                       | <input type="checkbox"/> Low Back Pain       | <input type="checkbox"/> Chronic Fatigue       |
| <input type="checkbox"/> Environmental Sensitivities | <input type="checkbox"/> Lyme Disease        | <input type="checkbox"/> Colitis               |
| <input type="checkbox"/> Extreme Weight Loss/Gain    | <input type="checkbox"/> Metal Poisoning     | <input type="checkbox"/> Diverticulitis        |
| <input type="checkbox"/> Fibroids                    | <input type="checkbox"/> Nausea/vomiting     | <input type="checkbox"/> Diarrhea              |
| <input type="checkbox"/> Fissure/Fistula             | <input type="checkbox"/> Nerve Disorder      | <input type="checkbox"/> Polyps                |
| <input type="checkbox"/> Gallstones                  | <input type="checkbox"/> Parasites/Fungi     | <input type="checkbox"/> Poor Appetite         |
| <input type="checkbox"/> Headache/Migraine           | <input type="checkbox"/> PMS                 | <input type="checkbox"/> Pregnant              |
| <input type="checkbox"/> Heartburn                   | <input type="checkbox"/> Prostate Problem    |  |
| <input type="checkbox"/> Heart Condition             | <input type="checkbox"/> Renal Insufficiency |  |

Do you use any of the following, and how often do you use? Antibiotics \_\_\_\_\_  
 Laxatives \_\_\_\_\_ Over the counter drugs \_\_\_\_\_ Steroids \_\_\_\_\_  
 Recreational drugs \_\_\_\_\_ Birth control \_\_\_\_\_ Tobacco \_\_\_\_\_  
 Prescription drugs (please list) \_\_\_\_\_  
 Supplements \_\_\_\_\_

Are you under the care of a physician? Yes \_\_\_ No \_\_\_. If yes, please provide name and telephone:

Do you exercise? \_\_\_\_\_ How often? \_\_\_\_\_ What type of exercise do you enjoy? \_\_\_\_\_

**Elimination:**

How many bowel movements to you usually have? Per Day \_\_\_\_\_ Per Week \_\_\_\_\_

Please circle: The stool: Floats Sinks Shows signs of mucous Shows signs of blood Has a strong odor

Do you strain to have a movement? Yes/No \_\_\_\_\_ Does the movement feel complete? Yes/No \_\_\_\_\_

**Diet:** Using the following key, please indicate your dietary usage. H = Heavy M= Moderate L = Light N = Never

- |                        |                       |                     |                    |
|------------------------|-----------------------|---------------------|--------------------|
| ___ Alcohol            | ___ Decaf Tea         | ___ Junk Food       | ___ Salt           |
| ___ Algae              | ___ Dried Fruit       | ___ Legumes         | ___ Smoothies      |
| ___ Antacids           | ___ Eggs              | ___ Nuts/Seeds      | ___ Soy            |
| ___ Aspirin            | ___ Fatty Foods       | ___ Organic Foods   | ___ Soda           |
| ___ Caffeinated Coffee | ___ Fish              | ___ Pasta           | ___ Sugar          |
| ___ Caffeinated Tea    | ___ Fresh Juice       | ___ Popcorn         | ___ Water          |
| ___ Carbonated Water   | ___ Fruit/Fruit Juice | ___ Poultry         | ___ Wheat Products |
| ___ Cheese             | ___ Green Leafy       | ___ Processed Foods | ___ Whole Grains   |
| ___ Chocolate          | ___ Vegetables        | ___ Protein Shakes  | ___ Yogurt         |
| ___ Dairy Products     | ___ Gum               | ___ Psyllium Fiber  |                    |
| ___ Decaf Coffee       | ___ Ice Cream         | ___ Red Meat        |                    |

I have read and agree to the following policies of Cornerstone Therapeutics:

- Please be on time. Late arrival will result in a shortened session and will be charged at the full rate. Cornerstone Therapeutics requires 24 hours notice for all cancellations or postponements, otherwise a \$40 fee will be charged. As a courtesy we give clients a telephone/text reminder a day before an appointment.
- Payment in full is due at the time of your visit. We accept cash and personal checks. Any returned checks will be charged a \$35.00 fee and cash payment will be required for all future visits.
- A referral from your primary health care provider or supervising physician is required if you have an acute condition or are following a prescribed treatment.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Informed Consent

I, the undersigned, authorize Lila Reader of Cornerstone Therapeutics to administer Colon Hydrotherapy sessions. Lila Reader is not a physician and therefore not qualified to diagnose or prescribe. As with any procedure, there are potential benefits and risks associated with it. I understand how Colon Hydrotherapy is performed and used, and I acknowledge the potential benefits and risks of it as described below:

Colon Hydrotherapy (or a colonic) is a gentle, purified water washing of the large intestine. The client lies on a padded table and, with a Colon Hydrotherapy instrument, purified and triple filtered water is run very slowly into the colon by the practitioner. When slight pressure builds up in the colon, the practitioner reverses the water flow to empty. As the water and waste are flowing out through an illuminated glass viewing tube, pressure points may be stimulated. This process is repeated several times during the period for 45-55 minutes. During one session, a total of approximately 2-5 gallons flows into and out of the large intestines. Cornerstone Therapeutics uses a closed Colon Hydrotherapy system with single-use, disposable speculum and tubing. The Colon Hydrotherapist is always present in the room with the client during each session.

Colon Hydrotherapy may be used to cleanse the colon by removing fecal material, gas and mucus. It may also be prescribed by a physician in preparation for the diagnostic study of the large intestine or for other conditions.

Potential risks may include possible aggravation of symptoms existing prior to the session, digestive distress, appetite changes or energy changes.

Possible contraindications are: severe cardiac disease, severe anemia, GI hemorrhage/perforation, severe hemorrhoids, cirrhosis, carcinoma of the colon, fissures/fistulas, advanced pregnancy, abdominal hernia, recent colon surgery (within 6 months) and renal insufficiency. If you have any of these conditions or are taking certain medications, you must consult your physician first. Your questionnaire will be reviewed at the first visit before you receive Colon Hydrotherapy to determine whether or not this procedure is appropriate for you.

- \*I affirm that I understand the purpose and potential benefits of Colon Hydrotherapy.
- \* I understand and freely accept the potential risks of the procedure.
- \* An offer has been made to answer any questions I have about the procedure.
- \* I freely and voluntarily consent to the above procedure.
- \* I realize that no guarantee as to the results that may be obtained has been given to me by Lila Reader.
- \* I hereby release Lila Reader from any and all liability, which may occur in connection with the above mentioned procedure.
- \* I understand that I am free to withdraw my consent and to discontinue participation in this procedure at any time.
- \* I am not acting as an agent for any government agency, law office or pharmaceutical company.

Signature of Client:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_