YELLOWSTONE NATUROPATHIC CLINIC
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Constitutional Hydrotherapy Consent

Goals and Treatment

The goal of Constitutional Hydrotherapy is normalize blood flow through the main organs of elimination: skin, liver, digestive tract, kidneys and lungs. Normalized blood flow leads to improvement in elimination, metabolism, and nutrition. This is accomplished through the mechanical effects of water on blood flow. For example, hot water will relax and open tissues and blood vessels while an ice pack will decrease inflammation and constrict blood vessels. The resulting "pumping action" provides much of the benefit of the treatment.

Naturopathic Physicians view blood as a vehicle to bring nutrition and health to cells. This treatment utilizes this principle by manipulating circulation in such a way that it enhances the immune response, improves overall nutrition, promotes detoxification and restores the nervous system to a more relaxed state.

Treatment Procedure

This procedure uses a series of hot and cold towels applied to the torso in conjunction with mild electrical stimulation (sine wave) to the back and abdomen. The sine wave is very mild and stimulates muscle contraction and nervous system thereby increasing circulation and metabolism especially to the digestive tract. Constitutional Hydrotherapy takes approximately one hour and usually a series of the treatments are recommended to achieve the most benefit.

The indications for this treatment are stress related illness, digestive tract problems (dyspepsia, Chron's disease, IBS, ulcerative colitis), infections, and circulatory problems.

Constitutional Hydrotherapy is not indicated for serious illness or very low vitality. Also, acute illness should not be treated alone with this procedure. Inform your treatment provider if you have metal implants, IUD's, metal piercing, active bleeding or pregnancy, malignancy or fracture near sine wave application sites.

Contraindications - Please mark any that are current:

___ Pacemaker	___ Pregnancy	___ Acute asthma
___ Over menstruating uterus	___ Over a cancerous tumor or lesion	___ Heavy aspirin use
___ Over metal (implant or jewelry)	___ Local bleeding or infected wound	___ Fear of treatment itself
___ High fever	___ Chronic Constipation	___ NONE

Your signature below means:

a. You read and understand the information provided on this form and agree to the foregoing.
b. You received all the information and explanation you desire concerning the procedure.
c. You authorize and consent to the performance of the procedure(s).

Patient/Representative: _____ _____
Print Name Signature
Date: _____ If signed by a representative, indicate relationship _____

Date: _____ Witness: _____

Physician's Signature:_____ Date:_____