INTRAVENOUS (IV) INFUSION THERAPY INTAKE FORM

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone_____ Date of Birth:____/____/_____ Age:_____ Sex: M / F

Occupation: _____ Email address: _____

In case of emergency, please contact: Name: _____ Phone:_____

How did you hear about us? ☐ Internet ☐ Facebook ☐ Walk-in ☐ Friend: _____

What are your main complaints? (Please check all that apply)

- ☐ Fatigue or low energy
- ☐ Stress
- ☐ Poor diet due to busy lifestyle
- ☐ Brain fog or trouble concentrating
- ☐ Low mood or depression
- ☐ Headaches or migraines
- ☐ Weight gain or difficulty losing weight
- ☐ Slow metabolism
- ☐ Asthma and Allergies
- ☐ Recent surgical procedure
- ☐ Recent illness
- ☐ Cold or flu symptoms
- ☐ Facial wrinkles or fine lines
- ☐ Dull or dry skin
- ☐ Malabsorption issues
- ☐ Other _____

Which statements best describe why you are here today? (Please check all that apply)

- ☐ I want to have more energy and feel better overall
- ☐ I want to do everything I can to nourish my body
- ☐ I want to do everything I can to enhance my weight loss efforts
- ☐ I want to prevent getting sick
- ☐ I want to recover quickly from my surgery or illness
- ☐ I want to slow the aging process
- ☐ I want to feel and look younger
- ☐ I want to have smoother, brighter and more vibrant skin
- ☐ I want to cleanse my body of toxins
- ☐ I want to recover quickly from a hangover
- ☐ Other_____

Are you pregnant or breastfeeding? Yes / No

Date of last chemistry screen or other lab testing _____

Have you ever been told that you have an electrolyte imbalance or other abnormal labs?

- ☐ Hypermagnesemia (High magnesium levels)
- ☐ Hypercalcemia (High calcium levels)
- ☐ Hypokalemia (Low potassium levels)
- ☐ Hemochromatosis (High iron levels)
- ☐ Other _____

Are you a diabetic? Yes / No

Are you a smoker? Yes / No If Yes, how much do you smoke? _____

How many alcoholic drinks do you consume in a week? _____

Do you use any recreational drugs? Yes / No

If Yes, which ones and how often? _____

Please list everything you are currently taking:

Prescription Medications – Strength – Frequency – Condition being treated

_____

_____

_____

Over the Counter Drugs – Strength – Frequency – Condition being treated

_____

_____

_____

Vitamins and Other Supplements – Strength – Frequency – Condition being treated

_____

_____

Do you take Digoxin (Lanoxin) for a heart problem? Yes / No

Do you take any diuretics or water pills? Yes / No If Yes, please list: _____

Do you take any steroids, i.e. Prednisone? Yes / No If Yes, please list: _____

Do you have any medication or food allergies? Yes / No If Yes, please list: _____

Do you have any of the following conditions? (Please check all that apply)

- ☐ Blood pressure problems (High or low)
- ☐ Heart Problems
- ☐ Stroke or "mini-stroke"
- ☐ Kidney Problems
- ☐ Kidney Stones
- ☐ Asthma
- ☐ Optic Nerve Atrophy or Leber's Disease
- ☐ Sickle Cell Anemia
- ☐ G6PD Deficiency
- ☐ Sarcoidosis
- ☐ Parathyroid problems (High levels)

List any other medical conditions you have (not mentioned above):

_____

_____

_____

List of all surgical procedures you've had with approximate dates:

_____

_____

_____

Is there anything else you'd like the nurse and physician to know?

_____

_____

_____

_____

This document is intended to serve as informed consent for your Intravenous (IV) Infusion Therapy as ordered by the physician at:

(Initials)_____ I have informed the nurse and/or physician of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the nurse and/or physician of my medical history.

(Initials)_____ Intravenous infusion therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any medical disease. These IV infusions are not a substitute for your physician's medical care.

(Initials)_____ I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

(Initials)_____ I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes.
3. Risks of intravenous therapy include but not limited to:
    a) Occasionally: Discomfort, bruising and pain at the site of injection.
    b) Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury. c)

    Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.
4. Benefits of intravenous therapy include:
    a) Injectables are not affected by stomach, or intestinal absorption problems. b)

    Total amount of infusion is available to the tissues.

    c) Nutrients are forced into cells by means of a high concentration gradient.
    d) Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

(Initials)_____ I am aware that other unforeseeable complications could occur. I do not expect the nurse(s) and/or physician(s) to anticipate and or explain all risk and possible complications. I rely on the nurse(s) and/or physician(s) to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered.

(Initials)_____ I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to IV Infusion Therapy, including any other procedures which, in the opinion of my physician(s) or other associated with this practice, may be indicated.

My signature below confirms that:

1. I understand the information provided on this form and agree to the all statements made above.
2. Intravenous (IV) Infusion Therapy has been adequately explained to me by my nurse and/or physician.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of Intravenous (IV) Infusion Therapy.
5. I release Dr. _____, and all the medical staff from all liabilities for any complications or damages associated with my Intravenous (IV) Infusion Therapy.

Patient's Name and Date of Birth– Please Print _____

Patient's Signature and Date _____

Nurse or Physician's Name – Please Print _____Signature_____Date_____