PATIENT NAME ________________ DOB____________

Nutritional IV Therapy Medical History

First Name:________________________________ Last Name: ________________________________

Address: ____

City/State/Zip _________________________________ Date Of Birth: __________________________

Best Contact Phone #: ___________________________ Email: _________________________________

Emergency Contact Name: ___________________________ Phone: ____________________________

Medical Questionnaire for Nutrient IV Therapy: In order for us to serve you better, please answer the following:

Check Yes or No: If yes to any question, please explain. Have you now or had in the past?

Question	Yes	No
Congestive Heart Failure?	Yes	No
Severe Renal Impairment?	Yes	No
Heart Attack/Stroke?	Yes	No
Condition of Sodium Retention or Electrolyte Imbalance?	Yes	No
Edema Water Retention?	Yes	No
High/Low Blood Pressure?	Yes	No
Severe Frequent Headaches?	Yes	No
Fainting/Seizures/Epilepsy?	Yes	No
Diabetes/Low Blood Sugar?	Yes	No
Any Liver Conditions? (e.g. Liver Cirrhosis, Liver Disease)	Yes	No
Any Allergies? If yes, please list here	Yes	No
Do you have Sulfa Allergies?	Yes	No
Do you have or have had asthma?	Yes	No
Females only: Are you pregnant?	Yes	No
Have you ever had a mastectomy? If so, which side?	Yes	No

Please list any current Diagnosis:

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Please list all medications you are currently receiving, including dosage:

Nutritional IV Therapy Medical History

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Allergies (including reaction):

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We reserve the right to refuse treatment to any patients we deem are intoxicated or unstable. The vast majority of our clients receiving our therapy feel greatly improved; however, every individual is different and there is no guarantee that you will feel better after an infusion; nor does your improvement of symptoms exclude other coexisting potential medical conditions.

I have informed the staff of any known allergies to drugs or other substances, or of any past reactions. 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 the opportunity to receive such information and give my concerns.

I understand that:

- The procedure involves inserting a needle into a vein and injecting the selected solution.
- Risks of IV therapy include, but are not limited to: Discomfort, bruising, and pain at the site of injection.
- Rarely: inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
- I understand the information provided on this form and agree to the foregoing.
- I have received all the information and explanation I desire concerning the procedure
- I authorize and consent to the performance of the procedure(s).

____ ________________

Patient Signature if over 18 yrs old Date

____ ________________

Parent/Guardian/POA if applicable Date

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