Mr. Mrs. Ms. Dr. **First Name:** _____ **Last Name:** _____
Address: _____ City & State: _____ Zip code: _____
Best Contact Phone #: (_____) _____ **Email:** _____
Emergency Contact Name: _____ Phone #: (_____) _____ Date of Birth: _____/_____/_____ Age: ____

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?

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
What is your medical history? Please list		
*Females Only: Are You Pregnant?	Yes	No

Terms, Conditions & Consent for IV Hydration Therapy

Our hydration therapy is specifically designed to counteract symptoms of dehydration, fatigue, and the residual effects of alcohol ingestion. We offer no diagnostic testing, make no medical diagnoses, and reserve the right to refuse treatment to any patients we deem are intoxicated deemed unstable, or whose symptoms are not consistent with the above. 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. This document is designed to serve as confirmation of informed consent for IV therapy as suggested by the qualified staff at **(write your practice name here)**.
I have informed the staff of any known allergies to drugs or other substances, or of any past reactions or anesthetics. I have informed the staff of all current medications and supplements I'm taking. 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 give my concerns.

I understand that:

- The procedure involves inserting a needle into a vein and injecting the selected solution.
- Risks of intravenous 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.
- Nutrients are forced into the cells by means of a high concentration ingredient.
- 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 procedures(s).

X:_____ _____

Signature Date

OFFICE USE INT: _____ *Comments:* _____