IV VITAMIN THERAPY CONSULTATION FORM

# CLIENT DETAILS

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Gender: ☐ Male ☐ Female ☐ Other

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name & Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP Name & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# MEDICAL HISTORY

**Please indicate if you currently have or have ever had any of the following conditions:**

☐ Heart disease or arrhythmias

☐ High or low blood pressure

☐ Epilepsy or seizures

☐ Cancer (active or in remission)

☐ Diabetes (Type 1 or 2)

☐ Kidney or liver disease

☐ Blood disorders or on blood thinners

☐ Asthma or respiratory disorders

☐ Thyroid conditions

☐ Autoimmune disease (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Anxiety, depression or other mental health concerns

☐ Recent illness, surgery, or hospitalisation (last 6 months)

☐ History of fainting or dizziness

☐ Allergies (including latex or medications): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or breastfeeding? ☐ Yes ☐ No ☐ N/A

Are you currently under the care of a GP or specialist? ☐ Yes ☐ No

If yes, please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all current medications, supplements, or herbal products:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# REASON FOR IV THERAPY

☐ Immune support

☐ Energy boost

☐ Skin brightening (e.g. Glutathione)

☐ Stress/mood support

☐ Hydration

☐ Recovery/performance

☐ General wellness

☐ Iron deficiency support

☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# LIFESTYLE & WELLBEING

Do you smoke? ☐ No ☐ Yes – how many per day? \_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? ☐ No ☐ Occasionally ☐ Frequently

Do you use recreational drugs? ☐ No ☐ Yes – specify: \_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? ☐ No ☐ Occasionally ☐ 3+ times/week

How would you rate your stress levels? ☐ Low ☐ Moderate ☐ High

How many hours of sleep do you get per night? \_\_\_\_\_\_\_\_\_\_

Do you follow a specific diet? ☐ No ☐ Yes – specify: \_\_\_\_\_\_\_\_\_\_

# CONTRAINDICATIONS TO IV VITAMIN THERAPY

**IV therapy may not be suitable if you have any of the following:**

• Kidney failure or dialysis

• Liver failure or cirrhosis

• Active infection or fever

• Uncontrolled high blood pressure

• Allergy to any ingredients in the IV formulation

• G6PD deficiency (for high-dose Vitamin C)

• Iron overload disorders (for iron infusions)

• Heart failure or recent cardiovascular events

• Pregnancy without medical clearance

# POSSIBLE SIDE EFFECTS

**Side effects are rare but may include:**

• Minor bruising or discomfort at injection site

• Light-headedness or dizziness

• Nausea or metallic taste

• Flushing or warmth sensation

• Headache or fatigue

• Allergic reaction (rare)

• Changes in blood pressure during infusion

These effects are typically mild and temporary. Please report any unusual or severe symptoms to the practitioner immediately.

# DISCLAIMER & CONSENT

I confirm the information I have provided is accurate and complete.

I understand IV vitamin therapy is not a replacement for medical care and results may vary.

I am aware of the possible risks and side effects associated with IV infusions.

I have disclosed all current medications, supplements, and relevant health information.

I consent to receive IV therapy and understand I can withdraw consent at any time.

☐ I agree and give my informed consent to proceed with IV vitamin therapy.

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

Practitioner Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_