METHYLENE BLUE IV 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

☐ G6PD deficiency (Glucose-6-Phosphate Dehydrogenase)

☐ Kidney or liver disease

☐ Respiratory conditions (e.g., asthma, COPD)

☐ Cancer (active or in remission)

☐ Blood disorders or on anticoagulants

☐ Thyroid conditions

☐ Psychiatric/mental health conditions

☐ Recent surgery or hospitalisation (last 6 months)

☐ Allergies (including to dyes, medications, latex): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Are you currently taking SSRIs, MAOIs, or any other antidepressants?

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 METHYLENE BLUE IV THERAPY

☐ Mitochondrial support

☐ Energy/fatigue reduction

☐ Brain fog or cognitive support

☐ Anti-aging or longevity

☐ Detoxification support

☐ Mood enhancement

☐ 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 METHYLENE BLUE IV THERAPY

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

• G6PD deficiency

• Pregnancy or breastfeeding

• Severe renal or hepatic impairment

• Taking SSRIs, SNRIs, MAOIs or serotonergic agents (risk of serotonin syndrome)

• Allergy to Methylene Blue or thiazine dyes

• Known sensitivity to phenothiazines or antidepressants

• Glaucoma (caution advised)

# POSSIBLE SIDE EFFECTS

**Side effects are generally mild and temporary but may include:**

• Blue/green urine and discolouration of body fluids (temporary)

• Nausea or gastrointestinal upset

• Dizziness or light-headedness

• Headache

• Anxiety or restlessness

• Tingling or numbness

• Staining of the skin at the injection site

• Risk of serotonin syndrome if used with serotonergic medications (rare but serious)

Most side effects resolve on their own. Please report any unusual or severe symptoms immediately.

# DISCLAIMER & CONSENT

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

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

I am aware of the possible risks, contraindications, and side effects associated with this infusion.

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

I understand this therapy may interact with certain medications (especially antidepressants).

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

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

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

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