NAD⁺ 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

**Do you currently have or have you ever had any of the following? Please tick all that apply:**

☐ Heart disease or irregular heartbeat

☐ High or low blood pressure

☐ Epilepsy or seizures

☐ Cancer (active or in remission)

☐ Diabetes (Type 1 or 2)

☐ Liver disease (e.g. hepatitis, cirrhosis)

☐ Kidney disease or dialysis

☐ Blood clotting disorders or on anticoagulants

☐ Glaucoma

☐ Gout or elevated uric acid

☐ Allergies (food, drugs, latex) – please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Autoimmune conditions – please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Thyroid disorders

☐ Psychiatric/mental health conditions (e.g. anxiety, depression)

☐ Neurological disorders (e.g. MS, Parkinson’s)

☐ Chronic fatigue or fibromyalgia

☐ Alcohol or drug dependency

☐ Any recent surgeries or hospitalisations in the last 6 months

Are you currently:

☐ Pregnant ☐ Breastfeeding ☐ Trying to conceive

List all medications, supplements, or herbal products you are taking:

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

# CONTRAINDICATIONS TO NAD⁺ IV THERAPY

**Please note you may not be suitable for NAD⁺ IV therapy if you have:**

• Uncontrolled high or low blood pressure

• Active cancer unless under supervision of a medical provider

• Liver or kidney failure

• Severe asthma or respiratory compromise

• Current infection or fever

• History of allergic reaction to NAD⁺

• Ongoing chemotherapy or radiation (unless authorised by oncologist)

• Recent major surgery (within 4 weeks)

• Active alcohol or drug detox not supervised by a clinician

• Pregnancy or breastfeeding (precautionary exclusion)

# NAD⁺-SPECIFIC QUESTIONS

1. Have you had NAD⁺ IV or injections before? ☐ Yes ☐ No

If yes, how did you respond? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. What is your primary reason for NAD⁺ therapy? (Tick all that apply)

☐ Energy/fatigue ☐ Detox support ☐ Addiction/recovery ☐ Anti-aging

☐ Focus/cognitive support ☐ Stress/mood ☐ Performance/recovery ☐ Sleep

☐ Neurological support ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Have you been diagnosed with any mitochondrial or neurodegenerative conditions? ☐ Yes ☐ No

If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Are you currently undergoing addiction recovery or withdrawal? ☐ Yes ☐ No

If yes, is this under medical supervision? ☐ Yes ☐ No

# LIFESTYLE QUESTIONS

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? ☐ No ☐ Occasionally ☐ Regularly

Hours of sleep per night: \_\_\_\_\_\_\_\_\_\_

Describe your current energy levels: ☐ Very Low ☐ Low ☐ Average ☐ Good ☐ Excellent

# POSSIBLE SIDE EFFECTS OF NAD⁺ IV THERAPY

**You may experience one or more of the following, usually during the infusion. These can be managed by slowing the rate:**

• Flushing or warmth

• Chest or abdominal tightness

• Light-headedness or dizziness

• Headache

• Nausea

• Muscle cramping

• Anxiety or restlessness

• Tingling or prickling sensation

• Temporary drop in blood pressure

• Fatigue post-infusion (rare)

These effects are usually temporary and resolve after slowing or stopping the infusion.

# DISCLAIMER & CONSENT

I confirm that all information I have provided is accurate and complete to the best of my knowledge. I understand that:

- NAD⁺ IV therapy is not a cure or substitute for medical treatment.

- It is not suitable for everyone and carries risks.

- I must notify the practitioner of any changes to my health or medication.

- I have been informed of the potential benefits and side effects.

- I have had the opportunity to ask questions and all have been answered to my satisfaction.

- The procedure has been explained to me and I understand I can stop treatment at any time.

☐ I confirm I have read and understood the information above.

☐ I consent to receive NAD⁺ IV therapy from this clinic.

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

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