Date_____ Time_____ IV Package_____Add-ons_____

Cost_____ CC CK CASH

INTRAVENOUS NUTRIENT THERAPY INTAKE FORM

Patient Information

Name: _____Height:_____Weight:_____

Address: _____

City:_____ State: _____ ZIP Code: _____

Phone: (H)_____ (C) _____

Date of Birth: _____ Age: _____ Sex: M / F

Occupation: _____ Email address: _____

In case of emergency, please contact Name: Phone:

How did you hear about us? ☐Internet ☐Instagram ☐Facebook ☐Other: ☐Friend:

What are your main complaints? (Please check all that apply)

☐ Fatigue or low energy

☐ Stress

☐ Poor diet due to busy lifestyle

☐ Brain fog or trouble concentrating

☐ Low mood or depression

☐ Cold or flu symptoms

☐ Hangover

☐ Dull or dry skin

☐ Malabsorption issues

☐ Other _____

Which statements best describe why you are here today? (Please check all that apply)

☐ I want to have more energy and feel better overall

☐ I want to do everything I can to nourish my body

☐ I want to do everything I can to enhance my weight loss efforts

☐ I want to prevent getting sick

☐ I want to recover quickly from my surgery or illness

☐ I want to slow the aging process

☐ I want to feel and look younger

☐ I want to have smoother, brighter and more vibrant skin

☐ I want to cleanse my body of toxins

☐ I want to recover quickly from a hangover

☐ Other _____

MEDICAL HISTORY

Are you pregnant or breastfeeding? Yes / No

Date of last chemistry screen or other lab testing _____

Have you ever been told that you have an electrolyte imbalance or other abnormal labs? (Please check all that apply)

☐ Hypermagnesemia (High magnesium levels)

☐ Hypercalcemia (High calcium levels)

☐ Hypokalemia (Low potassium levels)

☐ Hemochromatosis (High iron levels)

Other _____

Are you a diabetic? Yes / No

Are you a smoker? Yes / No If Yes, how much do you smoke? _____

How many alcoholic drinks do you consume in a week?

_____

Do you use any recreational drugs? Yes / No If Yes, which ones and how often?

_____

Please list everything you are currently taking:

Prescription Medications – Strength – Frequency-Condition being treated

_____

_____

_____

Over the Counter Drugs – Strength – Frequency – Condition being treated

_____

_____

_____

Vitamins and Other Supplements – Strength – Frequency – Condition being treated

_____

MEDICAL HISTORY CONTINUED

Do you take Digoxin (Lanoxin) for a heart problem? Yes / No

Do you take any diuretics or water pills? Yes / No If Yes, please list:

_____

Do you take any steroids, i.e. Prednisone? Yes / No If Yes, please list:

_____

Do you have any medication or food allergies? Yes / No If Yes, please list:

_____

Do you have any of the following conditions? (Please check all that apply)

☐ Blood pressure problems (High or low)

☐ Heart Problems (Arrhythmias)

☐ Stroke or "mini-stroke"

☐ Kidney Problems

☐ Kidney Stones

☐ Asthma

☐ Sickle Cell Anemia

☐ Sarcoidosis

☐ Parathyroid problems (High levels)

List any other medical conditions you have (not mentioned above):

_____

_____

_____

List of all surgical procedures you've had with approximate dates:

_____

_____

_____

Is there anything else you'd like the nurse and physician to know?

_____

IV Nutrient Therapy at Petrichor IV Hydration

Checklist of what to bring:

☐ Your completed Intravenous (IV) Infusion Therapy Intake Form

☐ A list of all prescription medications, OTC medications, vitamins/supplements that you take.

☐ A copy of your most recent blood work is helpful but not required.

☐ Your signed Consent Form

☐ Make sure you are well hydrated prior to your visit. We suggest drinking 1-2 16oz. bottles of water. Dehydration can make it difficult to insert an IV.

☐ Make sure you eat something prior to your visit. We suggest a high protein snack, such as nuts, seeds, a protein bar, cheese, yogurt or eggs. Low blood sugar can make you feel weak, lightheaded or dizzy.

During your first visit for IV Vitamin Therapy infusions:

During the first visit, a Registered Nurse will discuss your main complaints and desired outcomes with you. The RN will review your medical & surgical history and any medications you are taking. Based on this assessment, your Intravenous (IV) infusion will be customized to address your individual needs and a virtual visit with a physician will be performed if necessary.

What to expect:

The IVs used during your Intravenous (IV) infusion therapy are very similar to the IV therapy you would receive in a hospital or clinic setting. During this experience though, our IV infusions are given in a peaceful spa setting and leave you feeling calm, relaxed, and refreshed. All of our infusions last from 45-60 min. Our friendly and attentive staff will keep you calm, cared for, and comfortable during your infusion. Patients find the experience tranquil and healing. Patients leave feeling vibrant, energized, and refreshed.

Intravenous (IV) Nutrient Therapy Consent Form

This document is intended to serve as informed consent for your Intravenous (IV) Nutrient Therapy as ordered by the physician at Petrichor IV Hydration.

(Initials)_____ I have informed the nurse and/or physician of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the nurse and/or physician of my medical history.

(Initials)_____ Intravenous infusion therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any medical disease. These IV infusions are not a substitute for your physician's medical care.

(Initials)_____ I understand that IV Nutrient Therapy at Petrichor IV Hydration is only for otherwise healthy adults and is voluntary.

(Initials)_____ I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits.

(Initials)_____ I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes.
3. Risks of intravenous therapy include but not limited to: a) Occasionally: Discomfort, bruising and pain at the site of injection. b) Rarely: Inflammation of the vein used for

injection, phlebitis, metabolic disturbances, and injury. c) Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

4. Benefits of intravenous therapy include: a) Injectables are not affected by stomach, or intestinal absorption problems. b) Total amount of infusion is available to the tissues. c) Nutrients are forced into cells by means of a high concentration gradient. d) Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

(Initials)_____ I am aware that other unforeseeable complications could occur. I do not expect the nurse(s) and/or physician(s) to anticipate and or explain all risk and possible complications. I rely on the nurse(s) and/or physician(s) to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered.

(Initials)_____ I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to IV Nutrient Therapy.
My signature below confirms that:

1. I understand the information provided on this form and agree to all of the statements made above.
2. Intravenous (IV) Nutrient Therapy has been adequately explained to me by my nurse and/or physician.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of Intravenous (IV) Nutrient Therapy.

Patient's Name and Date of Birth– Please Print

_____

Patient's Signature and Date

_____

Registered Nurse – Please Print

_____

Registered Nurse Signature and Date

_____

Physician Name – Please Print

_____

Physician Signature and Date Reviewed

_____

Discharge Instructions for Intravenous (IV) Nutrient Therapy

How to care for yourself after your IV Nutrient Therapy:

- Apply pressure to site for 2 minutes after IV has been removed
- Keep Band-Aid in place for 1 hour
- Warm packs and elevating your arm can be used for any bruising at the site
- Cold packs can be used for pain relief and to decrease any swelling at the site
- Any swelling at the injection site should be significantly reduced in 24 hours
- Post IV infusion symptoms are uncommon. Dehydration is the cause of most symptoms and concerns.
- We encourage you to drink at least 1-2 16oz. bottles of water after your IV infusion.
- If enough water is not consumed, you may experience any of the following symptoms: headaches, nausea, joint pain, blurred vision, cramping (GI and/or muscular), mental confusion or disorientation.

Most patients experience significant overall improvements:

- Better energy
- Better mental clarity
- Improved sleep
- Improvement of their complaints
- Overall feelings of well being

Patients commonly report one of two patterns after an IV Vitamin Therapy infusion: •

- Patients generally feel better right away. Due to a busy lifestyle, many people are chronically dehydrated and deficient in vitamins and minerals causing them to not feel well. Once the patient is hydrated and the nutrients are replaced, their symptoms improve quickly.
- Patients sometimes feel tired or unwell. These patients are generally in the process of detoxifying. When toxins are pulled out of tissues, they re-enter the bloodstream. They remain poisons, but they are now on their way OUT instead of on their way IN. Even when patients do not feel well at this stage, the process is one of healing and cleansing. After this period, an overall improvement in one's sense of well-being is generally reported.

Call Petrichor IV Hydration or your Primary Care Physician for:

- Any symptoms you are not comfortable with
- If any of the following are progressively worsening after your IV infusion:

-Significant swelling over the IV site

-Redness over the vein that is increasing in size

- Pain in the vein/arm that is not improving over an 8-12 hour period

-Headache that does not resolve with increased hydration or over-the-counter pain relievers like Aspirin, Acetaminophen or Ibuprofen.

If you feel like you are having a life threatening emergency, please call 911.