CLIENT/PATIENT INFORMATION AND CONSENT

Full Name:		**Date of birth:**	
Phone #:		**Age:**	
E-mail:			
Address:			
City & State:		**Zip Code:**	
Emergency Contact Name:			

Medical Questionnaire For Nutrient IV/IM Therapy: In order for us to serve you better. Please answer the following:

	YES/NO
1. Congestive Heart Failure?	
2. Severe Renal Impairment?	
3. Heart Attack / Stroke?	
4. Condition of Sodium Retention or Electrolyte Imbalance?	
5. Edema Water Retention?	
6. High / Low Blood Pressure?	
7. Severe Frequent Headaches?	
8. Fainting / Seizures / Epilepsy?	
9. Diabetes / Low Blood Sugar?	
10. Any liver conditions? (e.g. Liver Cirrhosis, Liver Disease)	
11. Any allergies? If yes, please list here.	
12. Do you have Sulfa Allergies?	
13. Do you have or have had asthma?	

I understand that IV/IM therapy should not be used in patients with severe allergies, a history of anaphylaxis, or history or presence of multiple severe allergies or hypersensitivity to any of the ingredients in the vitamin mix, including glutathione. I have disclosed to my healthcare team any history of severe allergies or anaphylaxis that I have had and understand that failure to do so could result in serious bodily injury or death. _____ (Initial)

I understand and accept that IV/IM therapy carries with it both risks and benefits and I acknowledge that it is not possible for the healthcare team to screen me for each and every condition which could potentially interact with the IV/IM therapy in a negative way and hereby agree to hold them harmless from any and all injuries I sustain while undergoing IV/IM therapy. _____(Initial)

I have been advised by members of the healthcare team that alternatives to IV/IM therapy include but are not limited to diet, exercise, and consuming sports drinks/water as well as doing nothing at all. _____(Initial)

INFORMED CONSENT: Your consent for this procedure is strictly voluntary. By signing this informed consent form, you hereby grant authority to your provider to perform IV/IM therapy and/or to administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition. The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications have been fully explained to your satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this treatment.

I have read this informed consent and certify that I understand its contents in full. I hereby give my consent to this procedure and have been asked to sign this form after my discussion with the provider.

Patient signature/Date _____ _____

Witness signature/Date _____ _____