

# HYDRATIONBAR

## CLIENT INFORMATION

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Medical Questionnaire For Nutrient IV Therapy: In order for us to serve you better, please answer the following:**  
(Check Yes or No – If yes to any question, please explain and note if you have current or have had in the past.)

Y	N	Question	Past	Current	Explain
		Heart Failure / Heart Attack / Stroke?			
		Kidney Disease / Impairment?			
		Diabetes / Low Blood Sugar?			
		Edema / Water Retention?			
		High / Low Blood Pressure?			
		Severe or Frequent Headaches?			
		Fainting / Seizures / Epilepsy?			
		Liver conditions? (e.g. Cirrhosis / Hepatitis)			
		Sodium Retention or Electrolyte Imbalance?			
		Asthma?			
		Do you have Sulfa allergies?			
		Any other allergies?			
		*Females Only: Are You Pregnant?			
		Are you currently receiving chemotherapy?			
		Any other significant medical history?			

### Terms, Conditions & Consent for IV Hydration Therapy

Our hydration therapy is specifically designed to counteract symptoms of dehydration, fatigue, and the residual effects of nutrients and H2O depletion. We offer no diagnostic testing, make no medical diagnoses, and reserve the right to refuse treatment to any patients we deem are intoxicated, unstable, or whose symptoms are not consistent with the above. Majority of our clients receiving our therapy feel greatly improved; however, every individual is different and there is no guarantee that you will feel better after an infusion; nor does your improvement of symptoms exclude other coexisting potential medical conditions. This document is designed to serve as confirmation of informed consent for IV therapy as suggested by the qualified staff present at the current location. I have informed the staff of any known allergies to drugs or other substances, or of any past reactions to anesthetics. I have informed the staff of all current medications and supplements I am taking. I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information.

### I understand that:

- The procedure involves inserting a needle into a vein and injecting the selected solution.
- Risks of intravenous therapy include but are not limited to: discomfort, bruising, and pain at the site of injection.
- Other are but possible side effects include but are not limited to: inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
- Nutrients are forced into the cells by means of a high concentration ingredient.
- I understand the information provided on this form and agree to the foregoing.
- I have received all the information and explanation I desire concerning the procedure.
- I authorize and consent to the performance of the procedure(s).

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

Relationship to client (if signing for a minor): \_\_\_\_\_