Drip Wellness

www.Drip-Wellness.com

IV/IM THERAPY INTAKE FORM

CLIENT INFORMATION

Name ______________________ Date ______________

Date of Birth ______________________ Gender ______________

Address ____

City ______________ State ______________ Zip Code ______________

Email Address ______________________ Phone No ______________

Emergency Contact ______________________ Phone No ______________

How did you hear about us? ____

MEDICAL HISTORY

Please circle/check any relevant conditions you have or have had below:

- [ ] Adrenal gland issue
- [ ] Asthma
- [ ] Anaemia
- [ ] Autoimmune condition
- [ ] Blood disorder
- [ ] Cancer
- [ ] Diabetes
- [ ] Digestive/pancreas issues
- [ ] Emphysema/COPD
- [ ] Epilepsy/siezures
- [ ] Gout/arthritis
- [ ] G6PD deficiency
- [ ] Heart condition/murmur
- [ ] Hepatitis
- [ ] High blood pressure
- [ ] HIV/AIDS
- [ ] High blood cholesterol
- [ ] Infective endocarditis
- [ ] Infectious mononucleosis
- [ ] Kidney disease
- [ ] Liver condition
- [ ] Low blood pressure/fainting
- [ ] Parathyroid issues
- [ ] Phlebitis
- [ ] Respiratory condition
- [ ] Rheumatic fever
- [ ] Stroke
- [ ] Stomach/duodenum ulcer
- [ ] Thyroid condition
- [ ] Varicose Veins

Details or any other condition: ______________________________

____

Do you have any allergies? ☐ No ☐ Yes: ______________________________

☐ B12	☐ Calcium	☐ Pantothenic acid	☐ Thiamine
☐ Biotin	☐ Folic acid	☐ Potassium	☐ Vitamin C
☐ B-vitamins	☐ Magnesium	☐ Riboflavin	☐ Zinc

Please list any medication you take, including supplements or aspirin:

____

Are you currently taking any blood thinning drugs? ☐ No ☐ Yes

If yes, please explain: ______________________________

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes ☐ N/A

VISIT CONSULTATION

Have you previously received IV/IM Therapy? ☐ No ☐ Yes

Do you have a phobia of needles? ☐ No ☐ Yes

What are your reasons for seeking IV/IM Therapy? ______________________________

____

____

By signing below, I acknowledge that I have provided complete and accurate information and understand that it will be used to assess my suitability for any treatment. I understand that it is my responsibility to inform the staff of any changes to my medical history or daily routine. I agree to waive all liabilities of the staff for any injury or damages incurred due to misrepresentation of my health history.

______________________	______________________	__________
Client Name (printed)	Client Name (signed)	Date
______________________	______________________	__________
Staff Name (printed)	Staff Name (signed)	Date

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IV/IM THERAPY

consent form

I understand and acknowledge that I am voluntarily consenting to receive Intravenous (IV), and/or intramuscular (IM) therapy. I understand that the treatment involves the insertion of a small needle into a vein to administer fluids, medications, vitamins, or other therapeutic substances.

I acknowledge that, although IV/IM therapy is generally safe, there are inherent risks and potential side effects associated with this procedure. These risks include, but are not limited to:

- Infection at the site of the needle insertion
- Bruising or collection of blood at the injection site
- Nausea, dizziness or fainting spells
- Inflammation of the vein at the injection site may occur, leading to pain, redness, and swelling
- In rare cases, the fluid or medication being administered may leak into the surrounding tissue, potentially causing damage or discomfort
- Although rare, allergic reactions can occur, leading to rashes, itching, swelling, difficulty breathing, and in rare instances, cardiac arrest
- While extremely rare, there is a remote possibility of nerve damage at the injection site

I understand that the risks and potential side effects listed above are not exhaustive, and other unforeseen risks may arise. I agree that if I experience any of these side effects, I will contact my therapist and, if necessary, seek medical attention at my own expense. I understand that it is my responsibility to disclose any health condition or medication that might affect the treatment.

By signing below, I confirm that I have been fully informed of the potential risks, benefits, and complications and I voluntarily agree to undergo the treatment. I have had the opportunity to ask questions, and all my concerns have been addressed to my satisfaction. I release Drip Wellness, PLLC, and staff from any liability or claims arising from the treatment.

Client Name (printed)	Client Name (signed)	Date
Staff Name (printed)	Staff Name (signed)	Date