ESSENCE
WELLNESS CLINIC

IV INTRAVENOUS THERAPY INTAKE FORM

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (H) _____(Cell) _____

Date of Birth: _____(YYYY/MM/DD) Age: ____ Sex: M / F / □ _____

Occupation: _____ Email: _____

By providing your email, you agree to receiving clinic email reminders, health updates, promotions, etc.

In case of emergency, who should we contact: _____

How did you find out about our services? _____

Why would you like to receive IV Therapy?

_____

Have you received IV Therapy before? What was your experience like?

_____

Please check if you have any of the following conditions that IV Therapy can help with:

□ Fatigue	□ Low Depressed Mood	□ Anemia
□ Weight Issues	□ Irritability/Moodiness	□ Trying to get Pregnant/Fertility Prep
□ Stress	□ PMS	□ Allergies
□ Sleep Disorders	□ Asthma	□ IBS/Inflammatory Bowels
□ Low Immunity	□ Digestive Issues	□ Numbness/Tingling of body
□ Migraines	□ Muscle Spasms	□ Aging

Please list all allergies (known and suspected):

_____

_____

Please list all current and past medical conditions, diagnosis, hospitalizations, surgeries:

_____

_____

Please list all prescription drugs and supplements you are currently taking and doses:

_____

Date of last Physical Exam/Blood Test:_____

Any abnormal results from blood test?_____

Do you have any medical devices implanted in your body? Pins, Plates, Pacemakers?

_____

Please check if you have any of the diagnoses below:

□ High Blood Pressure	□ Arrhythmia	□ Abnormal EKG	□ CHF
□ Low Blood Pressure	□ Angina	□ MI / Heart Attack	□ Diabetes
□ Bleeding Disorder	□ Ankle Swelling	□ Kidney Disease	□ Asthma
□ G6PD Deficiency	□ Anxiety	□ Congestive Heart Failure	□ Edema
□ Sudden Weight Loss	□ Cancer		

Informed Consent for IV Treatment

You 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 you have had an opportunity to receive such information and to give your informed consent. The procedure involves inserting a needle into your vein and infusing a mixed formula of vitamins and minerals by your Naturopath. Alternatives to Intravenous Therapy is oral supplementation and/or dietary and lifestyle changes.

Risks of Intravenous Therapy include: fainting, discomfort, bruising and pain at the site of injection, inflammation of the vein used for injection (phlebitis), infection, severe allergic reaction, anaphylaxis, cardiac arrest and in extremely rare cases death.

Benefits of Intravenous Therapy include: 100% absorption of infused vitamins and minerals, total amount of infusion is available immediately to the tissues, nutrients are forced into cells by means of a high concentration gradient, higher doses of nutrients can be given than possible by mouth, without intestinal irritation.

You have the right to consent to or refuse any proposed treatment at any time prior to its performance. Your signature on this form affirms that you have given your consent of the procedure(s) described above with any different or further procedures which, in the opinion of your Naturopath, may be indicated. You understand the information provided on this form and agree to the foregoing. The procedure(s) set forth above has been adequately explained to you by your Naturopath. You have received all the information and explanation you desire concerning the procedure. You authorize and consent to the performance of the procedure(s).

Cancellation Policy: You are also aware of the clinic's late cancellation policy. There is a charge of 50% of the visit cost if you fail to give **less than 24 hours notice for cancellations**. You will be responsible to pay that charge before you can re-book.

Signature: _____ Date: _____
(YYYY - MM - DD)