iNFUSION
Cryotherapy & Laser Center

Client Intake – IV Therapy

Name: _____**Phone:** (_____)_____

Date of Birth: _____ **E-mail address**: _____

Address: _____**City:** _____**State/Zip:** _____

Emergency Contact: _____**Relationship**:_____ **Phone**: _____

How did you hear about iNFUSION? Circle choice: TV Radio Internet Another Client Word of Mouth

If referred by whom_____ **Other:** _____

I_____ hereby authorize the doctor(s) and nurses(s) at iNFUSION Cryotherapy and Laser Center to administer intravenous therapy to me. I understand that each physician independently contracts with the company, and is thus independently responsible for my medical care, and the company does not hold any responsibility for medical decisions made or treatments provided. I understand intravenous therapy is not a currently medically accepted procedure for treating any illness or concern and, thus, that it's used for this purpose may be considered by some insurance companies to be "medically unnecessary" or "experimental". I understand the procedure has some risks. Dr. Woodling or his staff have explained to me verbally the short and long-term risk, which may include discomfort, bruising, infiltration, infection and pain at the injection site; temporary worsening of my current symptoms or headache, tachycardia (increased heart rate), syncope (fainting), visual difficulties, shortness of breath, joint pains, red eyes, itchy eyes, nasal congestion, numbness, gastrointestinal disturbances and a very rare but serious reaction called anaphylaxis. I also understand that other unforeseeable complications or side-effects could occur.

I understand the intravenous procedure involves inserting a needle into your vein and infusing over a determined period of time the prescribe nutrients (vitamins, minerals, amino acids) or chelating agents. The intravenous treatment has benefits that are as follows: IV's or injectables are not affected by stomach or intestinal disease; total amount of infusion enters the blood stream and is available to the tissues; higher doses of nutrients can be given directly into the muscle or vein than by mouth thereby bypassing intestinal irritation when given by mouth; the vitamins might increase the over-all well being; and nutrients are forced into cells by means of a high concentration gradient. The possible benefits include mitigation or improvement of my current symptoms, improvement of respiratory function, decreased skin reactions, increased stamina, improved metabolism, to decrease in frequency or severity of headaches, improved concentration, and others.

I have read and understand the risks and benefits above and have had the opportunity to have all of my questions answered. I understand that I have the right to consent or refuse any proposed treatment at any time prior to the administering of my IV. I understand the information provided on this form and agree to the foregoing. I understand that there is no implied or stated guarantee of success or effectiveness of any treatment and that IV therapy may not mitigate, alleviate, or cure my condition(s). The procedure set forth above has been adequately explained to me. I understand that I am free to withdraw my consent and to discontinue participation and their treatments at any time. I understand that I must give 24-hour notice of intent to cancel or reschedule my appointment. I understand that I will incur the full fee for treatment, regardless of the amount used due to wasted materials.

My signature below confirms that I have received all the information and explanation that I desire concerning the intravenous therapy procedure. My signature below also confirms that I have given my consent to the IV therapy at iNFUSION Cryotherpy and Laser Center.

Patient Signature:_____ Date:_____

Present Status

Please answer these following questions as accurately as possible.

Name:_____

1. Have you ever had intravenous therapy before? Yes No
   If yes, did you have any adverse to this therapy?_____
2. Are you in good health at the present time to the best of your knowledge? Yes No
   If no please specify_____
3. Are you under a doctor's care at the present time? Yes No
   If yes, for what?_____
   Doctor's name_____
4. Are you allergic to any medications? Yes No
   If yes,what?_____
5. Have you had any serious injuries in the last year? Yes No
   If yes please specify:_____
6. Have you had any surgeries in the past year? Yes No
   If yes please specify:_____
7. Do you smoke cigarettes? Yes No
8. Do you drink alcohol? Yes No
9. Do you exercise regularly? Yes No
   If yes, how long (minutes)? _____ How often? _____
10. How would you rate your diet? Good Fair Poor

What is your main use of IV Therapy? (Circle all that apply)

Health and Wellness Athletic Performance

Stress Relief Rehydration

Cosmetic/Beauty Increase Energy

Medical Condition

Please list medical condition: _____

Family Medical History

Have you or any of your family members had:

You	Family	
_____	_____	High cholesterol
_____	_____	Heart disease, arrhythmia
_____	_____	Diabetes
_____	_____	High blood pressure
_____	_____	Asthma
_____	_____	Tuberculosis
_____	_____	Rheumatic fever
_____	_____	Thyroid disease
_____	_____	Liver disease
_____	_____	Stomach or bowel problems
_____	_____	Gallbladder problems
_____	_____	AIDS (HIV)
_____	_____	Are you currently pregnant?
_____	_____	Breast feeding?
_____	_____	Kidney disease
_____	_____	Glaucoma
_____	_____	Allergies
_____	_____	Breast problems
_____	_____	Blood transfusion
_____	_____	Cancer
_____	_____	Birth defects
_____	_____	Inherited diseases
_____	_____	Psychiatric illness
_____	_____	Nervous breakdown
_____	_____	Constipation/diarrhea

You	Family	
_____	_____	Difficulty w/ bowel movements
_____	_____	Lung Disease
_____	_____	Anemia
_____	_____	Pneumonia
_____	_____	Arthritis
_____	_____	GI bleeding disorder
_____	_____	Gout
_____	_____	Depression
_____	_____	Chest pain or tightness
_____	_____	Anxiety
_____	_____	Pyelonephritis
_____	_____	Stroke or TIA
_____	_____	Swollen ankles
_____	_____	Osteoporosis
_____	_____	Frequent headaches
_____	_____	Migraines
_____	_____	Feet swelling
_____	_____	Seizure disorder
_____	_____	Insomnia
_____	_____	Phlebitis
_____	_____	No known medical problems

Please list any other medical problems not listed.

_____

_____

Patient Signature: _____ Date:_____