Amberwood Terrace Integrated Health
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IV Nutrient Therapy Intake Form and Medical History

Patient Name: _____ DOB: _____ Age: _____ Today's Date: _____

Street Address: _____ City, State, Zip: _____

Cell Phone: _____ Email: _____ Sex (circle one): M or F

How did you hear about us? _____ Emergency Contact Name: _____

Emergency Contact Relationship: _____ Phone: _____

What are your goals with nutritional IV therapy? _____

_____

General Health

Are you currently seeing a physician for any reason? If yes, explain the reason. _____

Please list any health issues, past or present. _____

_____

Please list any allergies or sensitivities. _____

Do you smoke? If yes, how often? _____

Do you consume alcohol? If yes, how much/often. _____

How would you describe your diet? Please list any dietary concerns. _____

Do you exercise? If yes, how often and what type? _____

Please circle if you have any of the conditions listed or are being treated for any of the following:

Asthma, Diabetes, Fainting Spells, High Blood Pressure, Lyme Disease, Parkinson's Disease, Seizures, G6PD Deficiency, Addison's Disease, Multiple Sclerosis, Pregnancy, Congestive Heart Failure, Liver Disease, Kidney Disease
Other: _____

Have you had <u>any</u> surgeries or procedures? _____

Diagnostic Studies

Please indicate (circle) if you have had any of the following diagnostic studies: Genetic Testing, Micronutrients Panel, Vitamin D, Vitamin B12, Heavy Metals, Organic Acids, Food Sensitivities, Neurotransmitter, Cardio Panel, Thyroid, Sex Hormones, Other: _____
If you checked any of the above, please provide dates and test results as applicable.

Medications and Supplements

Please list all current prescription medications, over-the-counter drugs, supplements and vitamins you take regularly. Please include any you have taken in the past 3 months.

Have you ever had IV or Injectable vitamin therapy? If yes, when and what therapy? _____

Have you ever taken or currently take Blood Thinners? List drug type and dosage. _____

Have you ever had prolonged or regular use of NSAIDs? (e.g., Advil, Aleve, Motrin, Aspirin) _____

Have you had prolonged or regular use of Tylenol? _____

Informed Consent

This section is to serve as a confirmation of informed consent for IV therapy as ordered by a physician from Amberwood Terrace Integrated Health.

I understand that:

1. **The procedure involves inserting a needle in a vein or muscle in order to administer IV nutrient therapy.**
2. **IV nutrient therapy is not a substitute for your routine primary medical care.**
3. **Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.**
4. **IV therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure or prevent any medical disease.**
5. **The procedure will be performed by licensed health care providers, such as a Registered Nurse (RN), Licensed Practical Nurse (LPN) under the direction of a Nurse Practitioner.**
6. **Risks of intravenous therapy include but are not limited to:**
    a. **Occasional/Common: general discomfort, pain/bruising at the site of injection.**
    b. **Rare: Inflammation of the vein used for injection (Phlebitis), metabolic disturbances and injury.**
    c. **Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.**
7. **Benefits of intravenous therapy include:**
    a. **Infusions are not affected by stomach or intestinal absorption issues.**
    b. **Total amount of infusions is readily available to the tissues.**
    c. **Nutrients are forced into cells by means of high concentration gradient.**
    d. **Higher doses of nutrients can be given than possible by mouth without intestinal irritation.**

I have informed the ordering physician of any known allergies to drugs or other substances. I have informed the staff of all current medications and supplements, as well as any acute or chronic medical conditions.

I am aware that other unforeseeable complications could occur. I do not expect the medical staff to anticipate and/or explain all risk and possible complications. I understand the risks and benefits of the procedure and have had the opportunity to ask questions.

I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its initiation.

My signature on this form affirms that I have given my consent to IV therapy.

Patient Name: _____ Signature: _____ Date: _____

Staff Name: _____ Signature: _____ Date: _____

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INTEGRATED HEALTH