IV Infusion Therapy Patient Information

Demographics

Name: ___________________________ DOB: _______________ Height: _______ Weight: ______
Address: ____ City/State/Zip: __________________________
Phone #: ________________________ Email: ____
Occupation: ___________________________________ Employer: _________________________________
How did you hear about us? ____
Marital Status (Please Circle): **Married** **Separated** **Divorced** **Single** **Widow**

Emergency Contact Info:

Name: ____
Relationship: ____ Phone: _____________________________

Medication List:

________________________ ____________________ ____________________
________________________ ____________________ ____________________
________________________ ____________________ ____________________

Drug Allergies: Y/N If yes, please list: ____

Primary Care Physician and/or Prescribing Physician

Facility/Location: ____
Physician Name: ______________________________ Phone: ________________________________
Address: ____ Fax: __________________________________

Surgical History

- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Colonoscopy
- ☐ Gall Bladder Removal
- ☐ Knee Surgery
- ☐ Rhinoplasty
- ☐ Tonsillectomy
- ☐ Vasectomy
- ☐ Hysterectomy
- ☐ Breast Surgery
- ☐ Wisdom Teeth Removal
- ☐ Other: ___________________________

Social History

Smoker: Y/N
Do you chew/dip tobacco? Y/N
Do you use recreational drugs? Y/N
Do you drink alcohol? Y/N
Do you exercise? Y/N
Do you consume caffeine? Y/N

Comments: __________________________
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Medical History

Please mark any of the following that you have experienced or are currently experiencing:

- ☐ ADHD
- ☐ AIDS/HIV
- ☐ Acid Reflux
- ☐ Acne
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Blood Diseases
- ☐ Blood Transfusions
- ☐ Bone Problems
- ☐ Breast Cancer
- ☐ Cardiomyopathy
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Congestive Heart Failure
- ☐ Constipation
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ GI Problems
- ☐ Hair Loss
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Iron
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infertility
- ☐ Joint Problems
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorder
- ☐ Muscle Problems
- ☐ Osteoporosis
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Seizers/Epilepsy
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stroke
- ☐ Varicosities
- ☐ Water Retention

Other:

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Informed Consent For Intravenous (IV) Therapy & Chelation

This document is intended to serve as confirmation of informed consent for IV therapy and/or chelation as ordered by Paradigm Hormones

(Initials) ___________ I have informed the physician of any known allergies to drugs or other substances that may be included in the ingredients of my solutions, or of any past reactions to anesthetics.

(Initials) ___________ I have informed the doctor of all current medications and supplements.

I understand that I have the right to be informed during the procedure, and the risks and benefits. Procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

The IV intravenous procedure involves inserting a needle into your vein and infusing over a determined period of time, prescribed nutrients (vitamins, minerals, amino acids) or chelation agents.

I understand that risks, benefits and alternatives to IVs may include but are not limited

to:

1. The Risks and potential side effects

o Discomfort, bruising, and pain at the site of injection.

o Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.

o Severe reaction and/or anaphylaxis

2. The Benefits

o Injectables are not affected by stomach or intestinal disease.

o Total amount of infusion enters the bloodstream and is available to the tissues

o Higher doses of nutrients can be given by vein than by mouth without intestinal irritation that

can accompany doses given by mouth.

3. Alternatives to intravenous vitamin therapy are oral supplementation and/or dietary and lifestyle

changes.

I am aware that other unforeseeable complications could occur. I do not except the physician(s) to exercise judgement during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered. I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance.

My signature on this form affirms that I have given my consent to IV therapy with any different or further procedure, which in the opinion of my physician(s) or other(s) associated with this practice, may be indicated.

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. The procedures) set forth above has been adequately explained to me by my physician. I understand that I am free to withdraw my consent and to discontinue participation in their treatments at any time. I understand that, except in emergencies, I must give 24 hours notice of intent to cancel or reschedule my appointment. I understand that I will incur the full fee for treatment, regardless of amount used due to wasted materials.

My signature below confirms that:

1. I have received all the information and explanation I desire concerning the procedure.

2. I authorize and consent to the performance of the procedure(s)

Date: __________

Patient Name: ____________________________________

Patient Signature: ____________________________________

If signed by representative, indicate relationship: ______________________________

Patient/Representative Signature: ____________________________________