



20346 NW 2nd AVE Miami Gardens , Fl 33169

IV THERAPY INTAKE & CONSULTATION

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 select any relevant conditions below:

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



CLIENT INTAKE FORM IV THERAPY

Details or any other condition: _____

Do you have any allergies? No Yes: _____

- | | | | |
|-------------------------------------|-------------------------------------|---|------------------------------------|
| <input type="checkbox"/> B12 | <input type="checkbox"/> Calcium | <input type="checkbox"/> Pantothenic acid | <input type="checkbox"/> Thiamine |
| <input type="checkbox"/> Biotin | <input type="checkbox"/> Folic acid | <input type="checkbox"/> Potassium | <input type="checkbox"/> Vitamin C |
| <input type="checkbox"/> B-vitamins | <input type="checkbox"/> Magnesium | <input type="checkbox"/> Riboflavin | <input type="checkbox"/> 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 Therapy? No Yes

Do you have a phobia of needles? No Yes

What are your reasons for seeking IV 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 esthetician of any changes to my medical history or skincare routine. I agree to waive all liabilities of the esthetician or employer for any injury or damages incurred due to misrepresentation of my health history.

Client Name (printed)

Client Name (signed)

Date

Therapist Name (printed)

Therapist Name (signed)

Date

KM
BEAUTY & AESTHETICS



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IV THERAPY CONSENT FORM

I understand and acknowledge that I am voluntarily consenting to receive Intravenous (IV) Therapy treatment. 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 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 [Your Business Name] from any liability or claims arising from the treatment.

_____	_____	_____
Client Name (printed)	Client Name (signed)	Date

_____	_____	_____
Therapist Name (printed)	Therapist Name (signed)	Date

