Naturopathic IV Vitamin Therapy and IM Injection Intake Form

PERSONAL & CONTACT INFORMATION

NAME: ____
GENDER: ____________ ASSIGNED SEX: ____________
DATE OF BIRTH (YY/MM/DD): ______________________
AGE: __________ HEIGHT: ________ WEIGHT: _______

EMERGENCY CONTACT: __________________________

ADDRESS: ______________________________________
____
PHONE: _______________________________________
EMAIL: ____

PHONE: _______________________________________

HOW DID YOU HEAR ABOUT ME?

WOULD YOU LIKE TO BE SUBSCRIBED TO RECEIVE DR. ANNIE'S BLOG POSTS? YES ☐ NO ☐
If yes, please be sure to include your email address above

ALLERGIES

CURRENT MEDICATIONS & SUPPLEMENTS – Please include all prescription drugs, over the counter drugs (aspirin, antacids, laxatives, ...), birth control pills, herbs, vitamins, minerals, homeopathics, etc.

NAME	DOSE	REASON FOR TAKING	DATE STARTED	SIDE EFFECTS

REASON(S) FOR SEEKING IV / INJECTION THERAPY

Have you had IV therapy before? YES ☐ NO ☐
Have you had an intramuscular injection ("shot") before? YES ☐ NO ☐

HAVE YOU EVER BEEN DIAGNOSED WITH:

Hypertension (high blood pressure)
Low blood pressure
Angina
Ankle swelling
Congestive heart failure
Heart attack

Arrhythmia
Abnormal ECG
Kidney disease
Edema
Bleeding disorder
Asthma

Pulmonary edema
Sudden weight loss
Diabetes
Anxiety or panic attack
G6PD deficiency

Are you pregnant? YES ☐ NO ☐

Informed Consent for IV and/or injection therapy

I, ______________________________________, hereby request and consent to treatment with Naturopathic Medicine by Dr. Annie Cannon, ND.

_____ **Consent to Injections**: I consent to all injection procedures (including, but not limited to, vitamins, procaine, or other solutions) rendered by Dr. Cannon.

I understand that:

1. The procedure involves inserting a needle into various areas of the body and injecting of substances.
2. Risks of injection therapies include but are not limited to:
   - a. Occasionally to commonly:
     - i. Discomfort, severe pain, bruising, inflammation, injury and numbness at the site of injection.
     - ii. Fatigue, dizziness, or light-headedness after the injections.
     - iii. Fainting or loss of consciousness during the procedure.
   - b. Extremely Rarely:
     - i. Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

I am aware that other unforeseeable complications could occur. I do not expect Dr. Cannon to anticipate and/or explain all risk and possible complications.

_____ **Consent to Intravenous Therapy**: I consent to all intravenous therapy procedures (including, but not limited to micronutrient intravenous therapies) rendered by Dr. Cannon.

I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.
3. Risks of intravenous therapy include but are not limited to:
   - a. Occasionally to commonly:
     - i. Discomfort, bruising and pain at the site of injection.
   - b. Rarely:
     - i. Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
   - c. Extremely Rarely:
     - i. Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.
4. Benefits of intravenous therapy include:
   - i. Injectables are not affected by stomach, or intestinal absorption problems.
   - ii. Total amount of infusion is available to the tissues.
   - iii. Nutrients are forced into cells by means of a high concentration gradient.
   - iv. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

I am aware that other unforeseeable complications could occur. I do not expect Dr. Cannon to anticipate and/or explain all risk and possible complications.

I understand that it is my responsibility to inform Dr. Cannon immediately of the following and failure to do so could result in unnecessary avoidable complications for which I take full responsibility:

- Notify of all current disease conditions and any changes to my current disease state
- Notify of any medication, over the counter drugs or supplements and any changes to any of these (including new additions)
- Notify of any known allergies to drugs or other substances or any past reactions to anaesthetics
- Notify of pregnancy, suspicion of pregnancy, or breastfeeding

I understand that it is my responsibility to request that Dr. Cannon explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services has been made to me concerning the intended results of any treatment provided to me.

Privacy Policy

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

My signature below confirms that:

1. I have been provided ample opportunity to read this form or that it has been read to me.
2. I understand the information provided on this form and the procedures have been adequately explained to me and thus give my oral and written consent to evaluation and treatment.
3. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment from Dr. Cannon
4. I release Dr. Cannon from any and all liability associated with, but not limited to, the procedures mentioned herein.
5. I authorize and consent to the performance of the procedures listed herein.
6. I understand that I may withdraw my consent, in writing, at any time.

______________________ Printed name of Patient	______________________ Printed name of Guardian
______________________ Signed name of Patient	______________________ Signed name of Guardian
______________________ Date	______________________ Date

Cancellation Policy

We require **24 hours notice** for cancellation of Acupuncture, Naturopath and Massage appointments otherwise the full cost of the treatment will be charged to you.

We understand some circumstances are beyond your control, so please discuss with us when cancelling.

No shows will be charged the full treatment amount.