Jon'Ric INTERNATIONAL
MEDICAL SPA AND WELLNESS CENTER

IV Therapy

ALL SECTIONS MUST BE COMPLETED. PLEASE PRINT CLEARLY.

Today's Date: _____
Name: _____ Date of Birth: ____ /____ /____
Age: _____ Sex: _____ Height: _____ Weight: _____
Home Phone: ( )_____ Cell Phone: ( ) _____ Business Phone: ( )_____
Home Address: _____ E-mail Address: _____
City: _____ State: _____ Zip: _____
Emergency Contact: _____ Relationship to Patient: _____
Emergency Contact Phone: _____

Have you had IV Therapy before? [ ] Yes [ ] No
Were there complications? (If yes, please explain) _____

Please check if you have ever had any of the following:

Hypertension _____	Angina _____	Ankle Swelling _____	Arrhythmia _____
MI/Heart Attack _____	Abnormal EKG _____	Kidney Disease _____	General Edema _____
Bleeding Disorder _____	Asthma _____	Pulmonary Edema _____	Liver Disease _____
Diabetes _____	CHF _____	G6PD Deficiency _____	Anxiety or Panic Attacks _____

Please list any other previously diagnosed medical conditions:

_____

_____

Current Medications:
[ ] Yes [ ] No Please list any prescription or over-the-counter medications or vitamins that you are currently taking:

_____

_____

Allergies to Medications:
[ ] Yes [ ] No Are you allergic to any medications (aspirin, sulfa, etc.?) (If yes, please list)

_____

Other allergies: (latex, shellfish, milk, iodine, etc.)

_____

Please check yes or no to the following:

[ ] Yes [ ] No Do you smoke? If yes, number of packs per day _____ for how long? _____
[ ] Yes [ ] No Do you drink any alcoholic beverages? If yes, number of drinks per day: _____
[ ] Yes [ ] No Have you ever had a cold sore, Shingles or Herpes?

[ ] Yes [ ] No Do you take aspirin or blood thinners?
[ ] Yes [ ] No Do you exercise regularly?
[ ] Yes [ ] No Have you had a “reaction” to any anesthetic (Novocaine/Lidocaine) administered by a doctor?

Women:
[ ] Yes [ ] No Are you currently pregnant or breastfeeding?

IV Therapy involves inserting a needle into your vein or muscle and injecting a formula prescribed by your physician. All therapeutic services performed by practitioners at Jon ‘Ric Medical Spa and Wellness Center are aimed to promote health and well-being. However, adverse side effects may result. These include but are not limited to, local bruising, minor bleeding, fainting, temporary pain or discomfort at IV site, and/or temporary abdominal pain or discomfort.

Please answer the following:
[ ] Yes [ ] No I accept the fact that there are risks involved in every therapeutic procedure.
[ ] Yes [ ] No I acknowledge that IV Therapy is not covered by my insurance and I am responsible for the full fee.
[ ] Yes [ ] No I understand that results of my treatment are dependent upon full and complete disclosure of all medical information pertaining to me; and, that omission of issues relating to my health, current medications and allergies, or any other pertinent information may directly affect my personal safety and/or results.

Patient Signature _____ **Date** _____

Provider Signature _____ **Date** _____