Consent for Nutritional Therapy

Date: _____
Name: _____ Birthdate: _____
Address: _____
Phone: _____ E-mail: _____
Best form of communication: _____Text _____Call _____E-mail
Occupation: _____
Emergency Contact _____
Primary Physician: _____ Phone: _____

Please list any known allergies? _____
What is your reaction? _____
Are you pregnant? _____Trying to get pregnant? _____
Receiving Hormone Therapy? _____
Do you smoke? _____ How Often? _____
Do you drink alcohol? _____ How Often? _____
Have you ever taken Accutane? _____ If so, when? _____
Are you currently using any Retin-A, retinol products or Hydroquinone? _____
Do you use tanning beds, creams or bronzers? _____ How often? _____
Are you prone to cold sores? _____

What concerns you most? _____
Please list current, recent or chronic health conditions you are dealing with:

_____ _____ _____
_____ _____ _____

Please list medications and supplements you are currently taking:

_____ _____ _____
_____ _____ _____

I elect to receive nutritional vitamin therapy by subcutaneous injection, intramuscular injection or intravenous hydration infusion.
I understand that:

- Nutritional vitamin therapy does not claim or guarantee to treat or relieve any medical condition.
- Any procedure involves risks and each person experiences a different response.
- Risks and side effects may include redness, swelling, bruising, skin irritation, itchiness at the injection site, dizziness, fainting, nausea or headache. In rare cases a blood clot or an anaphylactic reaction may occur.
- Not providing my medical history before proceeding with treatment could impact results and cause complications.
- I declare that I am over 18, not under the influence of drugs or alcohol.

Before and after-treatment instructions have been discussed with me. The procedure, potential benefits, risks and alternative treatment options have been explained to my satisfaction. I consent to the proposed treatment today and in the future. Please let us know about any concerns or changes to your health. It is our goal to provide you with the best care possible.

Client/Guardian
Signature: _____ Date: _____

Provider Signature: _____ Date: _____