

MEDICAL HISTORY QUESTIONNAIRE & INFORMED CONSENT FORM FOR INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION (IMS) FOR NON-MEDICINAL INDICATIONS

This is your medical history form, to be completed prior to your first INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION session.

All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin the supplementation program.

This form is extensive, but please try to complete it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out. Your answers will help us design a supplementation that meets your individual needs.

If you have questions or concerns, we will help you with those after this form is completed. We realize that some parts of the form will be unclear to you. Do your best to complete the form. Your questions will be thoroughly addressed afterwards. It might be helpful for you to keep a written list of questions or concerns as you complete the medical history form.

Date:	DOB:
First Name:	Last Name:
Landline Number:	Mobile Number:
Address: _____ _____	
Emergency Contact	
Name:	Number:
GP/Consultant contact details	
Name:	Number:
I give/do not give my permission to inform my GP about the intravenous nutrient therapy that I am about to receive.	
Sign:	Date:
Place:	

Marital Status:

Single Married

Gender:

Male Female

Occupation: _____

What is your purpose for having this intravenous micronutrient supplementation (IMS)?

Have you had any Intravenous Nutrient Therapy before?

Yes No

Are you scared of needles/needle phobic?

Yes No

Do you faint easily when you have blood taken?

Yes No

Women only answer the following:

- Any menstrual period problems?
- Are you pregnant?
- Significant childbirth - related problems?
- Are you breastfeeding?

Comments: _____

Are you on any type of hormone replacement therapy? Yes No

Men only answer the following:

- Do you have Prostate problems?
- Do you have Erectile dysfunction?
- Are you taking hormone replacement i.e. testosterone?
- When was your last PSA bloodtest?

Comments: _____

Men and women answer the following:

List any prescription medications you are now taking: _____

List any self-prescribed medications, dietary supplements, or vitamins you are taking:

Date of last complete physical examination: _____

Normal

Abnormal

Never

Can't Remember

Comments: _____

List any other medical or diagnostic test you have had in the past two years:

List hospitalizations, including dates of and reasons for hospitalization:

List any drug or other causes of allergies including seafood (shellfish):

PAST MEDICAL HISTORY

Check those questions to which you answer yes (leave the others blank).

- Heart attack if so, how many years ago? _____
- Rheumatic Fever
- Heart murmur
- Diseases of the arteries
- High blood cholesterol
- Anaemia or other blood disorders i.e. Sickle Cell disease, Thalassaemia
- G6PD deficiency
- Varicose veins
- Arthritis/Gout of legs or arms
- Diabetes or abnormal blood-sugar tests
- Phlebitis (inflammation of a vein)
- Deep vein thrombosis/blood clot in the leg
- Dizziness or fainting spells
- Epilepsy or seizures
- Stroke
- Scarlet Fever
- Infective endocarditis
- Infectious mononucleosis
- Nervous or emotional problems
- Thyroid problems
- Parathyroid problems
- Adrenal gland problems
- Pancreas/digestion problems
- Stomach/duodenum ulcer
- Pneumonia
- Bronchitis

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- Emphyzema
- Asthma or Hay fever
- Abnormal chest X-ray
- Other lung disease
- Kidney disease
- Broken bones/osteoporosis
- Liver disease
- Jaundice or gall bladder problems
- Allergies including to shell fish?
- Leukemia or cancer
- Other _____

Comments:

Signature:

FAMILIAL DISEASES

Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

Check those questions to which you answer yes (leave the others blank).

- Heart attacks under age 50
- Strokes under age 50
- High blood pressure
- Elevated cholesterol
- Diabetes
- Asthma or hay fever
- Skin allergies
- Congenital heart disease (existing at birth but not hereditary)
- Heart operations
- Red blood cell disorders i.e. Sickle Cell, Thalassaemia, Anaemia
- Glaucoma
- Kidney disease
- Obesity (20 or more pounds overweight)
- Leukemia or cancer under age 60

Comments: _____

Signature:

CONSENT TO INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION

Before you choose to use the services of _____

Please read the following information FULLY AND CAREFULLY:

WHY INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION?

The main benefits may include:

1. Injectable micronutrients are not affected by stomach, or intestinal absorption problems
2. Total amount of infusion/injection is available to the tissues
3. Nutrients are forced into cells by means of a high concentration gradient
4. Higher doses of nutrients can be given than possible by mouth without intestinal irritation

I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

GOAL: The basic goal is to encourage people to become (1) knowledgeable about and responsible for their own health, (2) and to bring it to a personal optimum level, (3) to delay the aging process and to (4) enhance your metabolism.

INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION (IMS): is designed to improve your optimum health, absent of other non-nutritional complicating factors, and requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. It is not intended to make a medical diagnosis and to recommend any medicinal treatment(s).

No comment or recommendation should be construed as inferring or implying a medical diagnosis. Since every human being is unique, we cannot guarantee any specific result from INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION (IMS) protocols and programmes. Medication and or medical conditions may have a negative impact on the positive effects of IMS.

HEALTH CONCERNS: If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider such as your GP or Consultant. If you are under the care of another healthcare provider, it is important that you inform your other healthcare providers of your use of nutritional supplements. Nutritional therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important you always keep your physician informed of changes in your nutritional program.

If you are using medications of any kind, you are required to alert IVNT practitioner _____ to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist.

If you have any physical or emotional reaction to INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION (IMS), discontinue use immediately, and contact your IMS PRACTITIONER to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the supplementation.

Laboratory testing may be done to determine areas of dysfunction, not to diagnosis or treat. Lab testing can assist in revealing nutrient deficiencies and weaknesses, however in many cases nutrient blood tests are not a true reflection of body tissue levels.

However, although blood tests do not accurately reflect the nutrient status of nutrients in body tissues outside of the blood stream, certain blood tests are necessary to ascertain if vital organs are functioning normally. Below are a list of blood tests that are necessary even in healthy individuals:

Essential blood tests:

1. Full blood count
2. Liver function test
3. Kidney Function Tests
4. G6PD enzyme

Disclaimer: I was informed to have certain blood tests performed prior to having IVNT. However, I do not wish to have the blood tests performed and I am happy to have IVNT administered without the blood tests.

Patient Name:

Signature:

Date:

COMMUNICATION: Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products required to correct possible imbalances. It is your responsibility to do your part by following healthy dietary guidelines, exercise your body if possible, get plenty of rest, and learn more about nutrition health benefits.

You should request your other healthcare provider, if any, to feel free to contact

_____ for answers to any questions they may have regarding nutritional therapy.

I understand that:

1. The procedure involves inserting a needle into a vein and injecting the selected IMS protocol
2. Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes
3. Several supplementation sessions may be required
4. Risks of intravenous therapy include but not limited to:
 - Occasionally to commonly: discomfort, pain and bruising at injection site
 - Rarely: inflammation in the vein used, phlebitis, metabolic disturbances
 - Extremely rarely: severe allergic reaction, anaphylaxis, systemic infection, cardiac arrest and possible death

I am aware that other unforeseeable complications could occur. I do not expect _____ to anticipate and or explain all risk and possible complications. I rely on them to exercise judgment 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. **At any stage during the infusion/injection, I have the right to request that the procedure is terminated, however I accept that I will not be re-imbursed once supplementation has commenced.**

My signature on this form affirms that I have given my consent to an **INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION (IMS)** protocol as specified below (please tick):

PROTOCOL	SESSIONS		SESSIONS
IV Modified Myeres PLUS	_____	IV Vitamin C	_____
IV Performance Booster PLUS	_____	IV NADH	_____
IV Amino Muscle PLUS	_____	IV Procaine	_____
IV Fat Burner PLUS	_____	IV Customised Formula	_____
IV Immuno Booster PLUS	_____	IM Glutathione 600m/5ml SHOT	_____
IV Skin Brightening	_____	IM Methylcobalamin 5mg/2ml SHOT	_____
IV Hair Nourishment	_____	IM B-Complex SHOT	_____
IV Health Boost PLUS	_____	IM Fat Burner SHOT	_____
IV Energiser	_____	IM Vitamin D SHOT	_____
IV Advanced Energiser	_____	IM Biotin SHOT	_____
IV Glutathione	_____		

Comments: _____

Patient Name: _____

Signature: _____

Date: _____

Practitioner Name: _____

Practitioner Signature: _____

Date: _____

Place: _____

CUSTOMER RE-CONSENT FORM & CHANGE IN MEDICAL HISTORY

Session 2

Change in medical history? Yes No _____

Patient Signature:

Date:

Practitioner Signature:

Date:

Session 3

Change in medical history? Yes No _____

Patient Signature:

Date:

Practitioner Signature:

Date:

Session 4

Change in medical history? Yes No _____

Patient Signature:

Date:

Practitioner Signature:

Date:

Session 5

Change in medical history? Yes No _____

Patient Signature:

Date:

Practitioner Signature:

Date:

Session 6

Change in medical history? Yes No _____

Patient Signature:

Date:

Practitioner Signature:

Date: