Inland Naturopathic
WELLNESS CENTER
Regenerate Optimize Heal

Date: _____

Last Name: _____ **First Name:** _____

Date of Birth: _____ **Age:** _____

MEDICAL HISTORY:
Do you have any of the following conditions?

- ☐ Kidney disease or failure
- ☐ Liver Disease
- ☐ Heart failure or Cardiomyopathy
- ☐ Other: _____
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Seizures

Please List All Sensitivities/Allergies/Reactions:

Drugs: _____

Foods: _____

Environment: _____

Are you currently pregnant or breastfeeding?

☐ Yes ☐ No

Do you have a fear of needles or history of fainting?

☐ Yes ☐ No

Are you currently taking any supplements or medications?

☐ No
☐ Yes (list):

_____

_____

_____

Have you had any recent surgeries, hospitalizations, or infections?

☐ No
☐ Yes (explain):

_____

_____

_____

Reason for IV Therapy (Check all that apply):

- ☐ Energy boost
- ☐ Immune Support
- ☐ Hydration
- ☐ Skin Health
- ☐ Recovery (e.g., workout, illness, hangover)
- ☐ Detoxification
- ☐ Other:

_____

_____

Inland Naturopathic Wellness Center
314 N. Mountain Ave. Upland, CA 91786 | Phone: 909-981-9200 | Fax: 909-981-9220

CONSENT AND ACKNOWLEDGMENTS:

May not be suitable for those with small, fragile veins or veins with difficult access.

Do you have good veins?

☐ Yes ☐ No

POTENTIAL SIDE EFFECTS:

- Mild discomfort at the inject site, bruising, vein irritaiton or lightheadedness
- Rare reactions include allergic response

By signing below, I acknowledge that:

- I have disclosed all relevant health information
- IV Therapy does not replace medical treatment for serious conditions
- I consent to treatment and understand the risks involved.

Signature: _____ **Date**: _____

Print Name: _____

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