West Chester Wellness Center

IV THERAPY INTAKE FORM

CLIENT INFORMATION

Name ____________________ Date ____________

Date of Birth ____________________ Gender ____________

Address ____

City ____________ State ____________ Zip Code ____________

Email Address ____________________ Phone No ____________

Emergency Contact ____________________ Phone No ____________

How did you hear about us? ____

MEDICAL HISTORY

Please select any relevant conditions below:

- Adrenal gland issue
- Asthma
- Anaemia
- Autoimmune condition
- Blood disorder
- Cancer
- Diabetes
- Digestive/pancreas issues
- Emphysema/COPD
- Epilepsy/siezures
- Gout/arthritis
- G6PD deficiency
- Heart condition/murmur
- Hepatitis
- High blood pressure
- HIV/AIDS
- High blood cholesterol
- Infective endocarditis
- Infectious mononucleosis
- Kidney disease
- Liver condition
- Low blood pressure/fainting
- Parathyroid issues
- Phlebitis
- Respiratory condition
- Rheumatic fever
- Stroke
- Stomach/duodenum ulcer
- Thyroid condition
- Varicose Veins

CLIENT INTAKE FORM IV THERAPY

Details or any other condition: ____________________

____

Do you have any allergies? No Yes: ____________________

B12	Calcium	Pantothenic acid	Thiamine
Biotin	Folic acid	Potassium	Vitamin C
B-vitamins	Magnesium	Riboflavin	Zinc

Please list any medication you take, including supplements or aspirin:

____

Are you currently taking any blood thinning drugs? No Yes

If yes, please explain: ____________________

Are you pregnant or trying to become pregnant? No Yes N/A

VISIT CONSULTATION

Have you previously received IV Therapy? No Yes

Do you have a phobia of needles? No Yes

What are your reasons for seeking IV Therapy? ____________________

____

____

By signing below, I acknowledge that I have provided complete and accurate information and understand that it will be used to assess my suitability for any treatment. I understand that it is my responsibility to inform the esthetician of any changes to my medical history or skincare routine. I agree to waive all liabilities of the esthetician or employer for any injury or damages incurred due to misrepresentation of my health history.

____________________	____________________	__________
Client Name (printed)	Client Name (signed)	Date
____________________	____________________	__________
Therapist Name (printed)	Therapist Name (signed)	Date

West Chester Wellness Center

POLICY FORM

cancellation

At West Chester Wellness Center, we strive to provide an exceptional standard of care. In order to achieve this, we kindly request your cooperation in adhering to our cancellation policy.

We understand that life can be unpredictable and unexpected circumstances may arise. However, we kindly ask that you provide us with at least 48 hours' notice if you need to cancel or reschedule your appointment. Your deposit will be refunded or applied to a new appointment.

Cancellations made within 48 hours of the scheduled appointment time are subject to a $75.00] cancellation fee.

While we understand that unforeseen circumstances can occur, a missed appointment where no notice is given not only affects our ability to serve other clients but also results in lost time and resources. The full cost of the service is charged for these appointments.

We value your time as well as the time of our other clients. If you arrive more than 15 minutes late for your scheduled appointment, we may need to reschedule your session or shorten the treatment duration. The full price of the originally scheduled appointment will still apply.

We truly appreciate your understanding and cooperation in honoring our cancellation policy to ensure that each client receives the attention and quality service they deserve.

Client Name (printed)	Client Name (signed)	Date
Therapist Name (printed)	Therapist Name (signed)	Date

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West Chester Wellness Center

CLIENT RECORD

IV therapy

Name ______________________ Date of Birth ______________

Address ____

Email Address ____________________ Phone No. ______________

DATE	TREATMENT	PRODUCTS	COMMENTS	PRICE

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CARE ADVICE

pre and post treatment

Your body will recover more quickly and have optimal results when you maintain a regimen to support your health and well-being.

PRE-TREATMENT ADVICE:

- Have a snack before your IV therapy to maintain stable blood sugar levels. This helps prevent nausea and lightheadedness.
- Wear loose and comfortable clothing to your appointment - this will allow easy access to your arm for the IV placement.
- Stay hydrated prior to your treatment - when your body is dehydrated, your veins contract, making it more difficult to receive IV therapy.
- Avoid taking antihistamines or decongestants the morning of your appointment - these can cause your veins to constrict.
- IV therapy takes between 30-45 minutes - we recommend bringing something quiet that you can do while sitting down.

POST-TREATMENT ADVICE

- Wait at least 1 hour before wetting the injection site and wait 24 hours for any strenuous activity.
- Continue to stay hydrated following IV therapy - this helps to maintain the treatment benefits and supports your well-being.
- Avoid any rough contact of the area for 48 hours to prevent irritation.
- You can shower/bathe as usual following an IV therapy session.
- IV therapy is a supplement to a healthy lifestyle. Continue to eat a balanced diet, exercise regularly, and get enough sleep to support your overall well-being.

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FAQ'S

IV therapy

WHAT ARE THE BENEFITS OF IV THERAPY?

IV therapy offers numerous benefits, such as increased hydration, improved nutrient absorption, enhanced immune support, faster recovery from illness or fatigue, improved athletic performance, and relief from certain symptoms like headaches and nausea.

IS IV THERAPY PAINFUL?

Most people experience minimal discomfort during IV therapy. The initial needle insertion may cause a slight pinch, but once the catheter is in place, the discomfort is usually minimal. A skilled nurse will ensure the procedure is as painless as possible.

WHAT CONDITIONS CAN BE TREATED WITH IV THERAPY?

IV therapy can be used to treat various conditions, including dehydration, vitamin deficiencies, fatigue, migraines, hangovers, common colds and flu, athletic performance enhancement, and general wellness support.

HOW FREQUENTLY SHOULD I GET IV THERAPY TREATMENTS?

The frequency of IV therapy treatments depends on your specific needs, and health goals. Some individuals may benefit from weekly or monthly treatments, while others need occasional sessions for specific goals.

IS IV THERAPY COVERED BY INSURANCE?

In most cases, IV therapy for general wellness or non-medical purposes is not covered by insurance. However, if you have a medical condition that requires IV therapy, it's worth checking with your insurance provider to see if it is covered under your policy.

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IV THERAPY

consent form

I understand and acknowledge that I am voluntarily consenting to receive Intravenous (IV) Therapy treatment. I understand that the treatment involves the insertion of a small needle into a vein to administer fluids, medications, vitamins, or other therapeutic substances.

I acknowledge that, although IV Therapy is generally safe, there are inherent risks and potential side effects associated with this procedure. These risks include, but are not limited to:

- Infection at the site of the needle insertion
- Bruising or collection of blood at the injection site
- Nausea, dizziness or fainting spells
- Inflammation of the vein at the injection site may occur, leading to pain, redness, and swelling
- In rare cases, the fluid or medication being administered may leak into the surrounding tissue, potentially causing damage or discomfort
- Although rare, allergic reactions can occur, leading to rashes, itching, swelling, difficulty breathing, and in rare instances, cardiac arrest
- While extremely rare, there is a remote possibility of nerve damage at the injection site

I understand that the risks and potential side effects listed above are not exhaustive, and other unforeseen risks may arise. I agree that if I experience any of these side effects, I will contact my therapist and, if necessary, seek medical attention at my own expense. I understand that it is my responsibility to disclose any health condition or medication that might affect the treatment.

By signing below, I confirm that I have been fully informed of the potential risks, benefits, and complications and I voluntarily agree to undergo the treatment. I have had the opportunity to ask questions, and all my concerns have been addressed to my satisfaction. I release [Your Business Name] from any liability or claims arising from the treatment.

Client Name (printed)	Client Name (signed)	Date
Therapist Name (printed)	Therapist Name (signed)	Date

West Chester Wellness Center

RELEASE FORM

photo & video

I, ______________________ grant and authorise ______________________ the right to take, edit, alter, use and publish photographs and/or videos of me for the purpose of promotional materials, including but not limited to:

- Print advertisements
- Online marketing (websites, social media, blogs)
- Educational materials (brochures, flyers, presentations)

I acknowledge that all photographs and/or videos taken are the property of Wellness Centers and will be used solely for the purposes stated above.

I understand that by signing this release form, I grant West Chester Wellness Center permission to take, edit, alter, use and publish my photographs and/or videos without any further compensation or consideration. I waive any rights to compensation, financial or otherwise, for the use of these photographs and/or videos.

i release WC Wellness Center its representatives, and employees from any claims, damages or liabilities that may arise from the use of the photographs and/or videos, including any claims for compensation, defamation, or invasion of privacy.

By signing below, I acknowledge that I have read this release form, understand its content, and voluntarily agree to its terms.

Client Name (printed)	Client Name (signed)	Date
Therapist Name (printed)	Therapist Name (signed)	Date