

**Sonflower Health and Wellness
CLIENT INTAKE & HISTORY FORM**

First Name _____ Last Name _____

Address _____ City & State _____ Zip Code _____

Best Contact Number _____ Email _____

Emergency Contact Name _____ Phone Number _____ Relationship _____

Date of Birth _____

For us to provide quality appropriate services tailored to your individual needs, please answer the following. Check Yes or No. If Yes to any question please explain. Do you have now or have you had in the past?

QUESTION	YES	NO
1. HYPERTENSION (HIGH BLOOD PRESSURE)		
2. HYPOTENSION (LOW BLOOD PRESSURE)		
3. CONGESTIVE HEART FAILURE (CHF)		
4. HEART ATTACK OR STROKE		
5. RENAL IMPAIRMENT OR RENAL FAILURE		
6. WATER RETENTION		
7. SEVERE OR FREQUENT HEADACHES		
8. SEIZURE, EPILEPSY, SYNCOPES/ FAINTING		
9. LIVER CONDITIONS (LIVER DISEASE, CIRRHOSIS, HEPATITIS)		
10. ASTHMA		
11. ANAPHYLAXIS (SEVERE ALLERGIC REACTION)		
12. DIABETES OR LOW BLOOD SUGAR		
13. ELECTROLYTE IMBALANCE OR SODIUM RETENTION		

14. CARDIAC ARRHYTHMIAS		
15. CANCER		
16. HIV/ AIDS		
17. BLEEDING OR CLOTTING DISORDERS		

CIRCLE ONE:

Females: Are you pregnant? YES NO Are you breastfeeding? YES NO

Have you been hospitalized or under the care of a physician in the past 30 days? YES NO

Please describe any medical history and any medical conditions

Current list of medications (including prescriptions and over-the-counter vitamins, herbs, and supplements)

Allergies _____ Type of reaction _____

PLEASE INITIAL BELOW:

If you answered yes to any of the questions, you may require further consultation, may not be suitable for IV Nutrient Hydration Therapy/Vitamin Injections, and may be denied services

I am fully aware that participating in Intravenous (IV) Nutrient Hydration and vitamin administration services by Sonflower Health and Wellness carries risk _____

I have truthfully answered all questions regarding my current and past medical history and have informed the staff about any current medication and/or over-the-counter drugs I am taking, as well as street and/or recreational drugs _____

I understand that failure to disclose my medical issues and/or drug use can lead to serious complications _____

I acknowledge that I am responsible for any medical care I may have that is directly or indirectly related to the services provided by Star Beauty Bar & Wellness. If I seek medical treatment for any side effect or reaction, it will be at my own expense _____

I acknowledge and agree that the sole risk of injury or harm resulting in any manner from my voluntary participation in Sonflower Health & Wellness services rests entirely with me to the extent that I fail to disclose my health condition (s), medications, or drug use in advance of services provided _____

I expressly represent and warrant to Sonflower Health & Wellness that I have never been diagnosed with or treated for any illnesses or conditions that may result in increased risk when participating in the services provided. _____

I understand that Sonflower Health & Wellness bears no responsibility for and will not screen for, diagnose, monitor, or provide care for such conditions _____

I acknowledge that Sonflower Health & Wellness relies upon the information provided by me in assessing my ability to participate in the services provided _____

There is no guarantee that hydration therapy will temporarily or permanently cure or resolve your hangover, effects of altitude sickness, dehydration, or viral illness _____

We do not promote alcohol use, however, if you engage in use please do so in moderation. Heavy drinking after hydration therapy can lead to stomach irritation or other complications. Hydration therapy is not a cure for heavy drinking. Excessive drinking can lead to alcohol poisoning and other serious medical problems _____

I acknowledge that I have been allowed to discuss the nature and purpose of the treatment, risks, complications, consequences, and benefits of the procedure _____

I waive all claims and agree to hold Sonflower Health & Wellness harmless regarding any complications or consequences I experience during the following services_____

My signature below confirms that: I am 18 years or older, and authorize and consent to the services provided. I have been adequately explained the procedures and received all the information that I desired. _____

This serves as informed consent for IV Nutrient Hydration services and Vitamin Shots

Sign Here _____

IV NUTRIENT HYDRATION AND VITAMIN ADMINISTRATION RISKS INCLUDE THE FOLLOWING:

- Injury
- Bleeding
- Infection
- Inflammation/ Swelling
- Bruising
- Phlebitis
- Air embolism
- Fluid Overload
- Adverse reaction to medication
- Nerve injury
- lightheadedness/fainting
- Misplacement of IV line in the body
- Extravasation of fluid in the body

I have read and acknowledge the above risks,

Client first and last name

Date

