**Southtowns Colon Hydrotherapy- Essential IV Therapy of Orchard Park**

6576 East Quaker Street, Suite 3, Orchard Park NY 14127

716-982-4703 (Text)

**MEDICAL INTAKE & INFORMED CONSENT**

Sara Sargent, RN

Kim Mecca, RN, CNM

Melissa Rosner, RN, NP

Bailey Milleville, RN

Juliann Lazzaro, APRN, MSN, CNM – Medical Director

**DATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physicians Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY-**

Have you ever been hospitalized? If so, explain…

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under a doctor’s care for any illness/condition?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from anxiety, depression, bipolar? If so, how long?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies- Medication & Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list ALL prescription, over the counter and supplements you are currently taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received IV Vitamins-Nutrition in the past?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or breastfeeding? \_\_\_\_\_\_\_\_\_\_

Have you ever been told that you have abnormal lab results (check all that apply):

\_\_\_\_\_ Hypermagnesemia (high magnesium) \_\_\_\_\_ Hypercalcemia (high calcium)

\_\_\_\_\_ Hypokalemia (low potassium) \_\_\_\_\_ Hemochromatosis (high iron)

\_\_\_\_\_Are you diabetic?

\_\_\_\_\_Are you a smoker? \_\_\_\_\_\_\_\_Marijuana \_\_\_\_\_\_\_Tobacco \_\_\_\_\_Illicit drug use

\_\_\_\_\_Do you drink alcohol? Never­­­­­­­­­­\_\_\_\_\_Rarely\_\_\_\_\_\_Moderately\_\_\_\_\_Daily\_\_\_\_\_

Do you have any of the following conditions (check all that apply):

\_\_\_\_\_Blood pressure problems (high or low)

\_\_\_\_\_ Heart Attack or Heart problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Stroke

\_\_\_\_\_ Kidney or Bladder problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Asthma \_\_\_\_\_Sickle Cell Anemia

\_\_\_\_\_Sarcoidosis \_\_\_\_\_Liver disease or Liver problems

\_\_\_\_\_Iron Overload (Hemochromatosis) \_\_\_\_\_Leaky Gut Syndrome

\_\_\_\_\_Thyroid disease/Parathyroid disease

BOWEL HABITS (**SKIP THIS SECTION IF NOT DOING COLON HYDROTHERAPY**)

* How often do you have a bowel movement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Consistency? Hard / Soft / Watery / Pellets
* Do you strain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Hemorrhoids? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Rectal Bleeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   How frequent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Last Colonoscopy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PARASITES:
  1. Mucous? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  2. Dark Circles under eyes? \_\_\_\_\_\_\_\_\_\_\_\_
  3. Do you grind your teeth? \_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL INFORMATION**

Water Consumption per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you frequently use any of the following?  List the type and frequency (if applicable):

Laxatives:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Antacids: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tylenol/Aspirin/Advil: \_\_\_\_\_\_\_\_\_\_\_

Number of antibiotic treatments in the last 5 years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you take antibiotics frequently as a child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of adverse reactions to immunizations:  Yes or No

Dietary restrictions (religious, vegetarian/vegan, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any history of eating disorder? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any history of emotional, physical or sexual abuse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT- COLON HYDROTHERAPY**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ wish to acknowledge that the above-named practitioner is helping me with natural hygiene at my own request.

I understand that I know the above-named practitioner is not a medical doctor and will not diagnose, treat, operate or prescribe for any human disease, pain, deformity or physical condition, nor will he/she offer to do so.

I am here on this and any subsequent visits solely on my own behalf and not as an agent for any Federal, Municipal, or Professional agency on a mission of entrapment or investigation.

I am agreeing that to the best of my **knowledge I am not pregnant, I have not been diagnosed with Crohn’s Disease or Colitis.**

**It is our Policy at Southtowns Hydrotherapy to charge in full for any Appointment that has been Cancelled or Missed Without 24-hour notice. All future Appointments will be paid prior to your next appointment. Please arrive on time for your appointment or your appointment will need to shortened or rescheduled without a refund.**

I acknowledge that I have read, understand and agree with all the above statements by my signature and I am signing voluntarily and not under duress of any kind.

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INFORMED CONSENT- IV Therapy & Injections**

This document is intended to serve as an informed consent for your Intravenous (IV) Infusion Therapy or Intramuscular Injection(s) as prescribed by the medical staff at Southtowns Colon Hydrotherapy-Essential IV Therapy of Orchard Park. You will need to sign after reading below.

I have informed the Nurse Practitioner or Nurse of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the staff of my complete medical history.

Intravenous Infusion Therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration and are not intended to diagnose, treat, cure, or prevent any medical disease. These IV infusions are not a substitute for your physician’s medical care.

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.

I understand the following:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution. Intramuscular injections involve inserting a needle into a large muscle and injecting the solution.

2. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.

3. Risks of intravenous therapy include but are not limited to:

a) Occasionally: Discomfort, pain, and burning at the site of injection .

b) Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.

c) Extremely Rare: Severe allergic reaction, anaphylaxis, cardiac arrest, death, air embolism, fluid overload, medication adverse interactions, and nerve injuries.

4. Benefits of intravenous therapy include:

a) Injectables are not affected by stomach or intestinal absorption problems.

b) Total amount of the infusion is available to the tissues.

c) Nutrients are forced into cells by means of a high concentration gradient.

d) Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

I am aware that other unforeseeable complications could occur. I do not expect the Nurse Practitioner, Nurse, and/or Physician to anticipate and or explain all the risk and possible complications. I rely on the Nurse Practitioner, Nurses, and/or Physician to exercise judgement 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.

My signature on this form affirms that I have given my consent to IV Infusion Therapy including any other procedure which, in the opinion of my health care provider may be indicated. My signature below confirms that:

1. I understand the information provided on this form and agree to all the statements made above.

2. Intravenous (IV) Infusion Therapy has been adequately explained to me by the provider at Southtowns Colon Hydrotherapy.

3. I have received all the information and explanation I desire concerning the procedure.

4. I authorize and consent to the performance of Intravenous (IV) Infusion Therapy.

5. I release Juliann Lazzaro, APRN, MSN, CNM, Southtowns Colon Hydrotherapy, and all the medical staff from all liabilities, complications, or damages associated with my Intravenous (IV) Infusion Therapy.

**IN THE EVENT OF AN EMERGENCY, CALL 911 OR PROCEED TO THE NEAREST EMERGENCY ROOM. ACKNOWLEDGMENT:** I confirm that I have read this form and fully understand its contents.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the sessions and programs offered by Southtowns Colon Hydrotherapy, LLC. I understand the nature of the sessions and programs and that participating in them carries risks. I have been given an opportunity to ask questions, and all of my questions have been answered fully and to my satisfaction. I agree to my assumption of all risks associated with my participation.

Medical Professional Certification. I hereby certify that I have explained the nature, purpose, benefits, risks of, complications from, alternatives to (including no participation by the client and any attendant risks), the proposed regimen, sessions and programs, have offered to answer any questions and have fully answered all such questions. I believe that the client/agent/relative/guardian fully understands what I have explained.

**It is our Policy at Essential IV Therapy to charge in full for any Appointment that has been Cancelled or Missed Without 24-hour notice. All future Appointments will be paid prior to your next appointment. Please arrive on time for your appointment or your appointment will need to shortened or rescheduled without a refund.**

**SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**