THE DRIP

Mobile IV Infusion Therapy

PLEASE COMPLETE ALL PAGES AND EMAIL TO HYDRATE@THEDRIPCA.COM.

These documents must be received 24 hours prior to appointment.

DATE: _____

MENU:

☐ QUENCH ☐ ENERGIZE ☐ THE MAX ☐ THE HANGOVER

☐ GLOW ☐ RELIEF ☐ IMMUNITY

ADD ON:

☐ Anti-Nausea ☐ Anti-Inflammatory ☐ Glutathione ☐ B-12 Injection

CLIENT INFORMATION:

LAST NAME	FIRST NAME	MI
DOB	CELL PHONE	AGE
STREET ADDRESS		APT/UNIT #
CITY	STATE	ZIP
EMAIL		
EMERGENCY CONTACT	CELL PHONE	
PRIMARY CARE PHYSICIAN		MAY WE CONTACT IF NECESSARY?

Have you had IV Infusion Therapy in the past? YES / NO

If Yes, please tell us what type of IV Infusion Formula: _____

_____

Are you pregnant? YES / NO

Please note if you are a Mom to Be, you need to wait for IV until after your bundle of joy is born.

Are you regularly exposed to toxins or other pollutants (work, home, hobbies, etc.)? Please describe:

_____

_____

How stressful is your life? How well do you handle these stressors? _____

_____

CLIENT NAME:_____ **DOB:** _____

PHARMACY INFORMATION

Name: _____Pharmacy Phone Number: _____

Address: _____

PRESCRIPTION AND NON-PRESCRIPTION MEDICINES, VITAMINS, SUPPLEMENTS, BIRTH CONTROL. ❑None

Medication	Dose & Times per day	Medication	Dose & Times per day

SOCIAL AND RECREATIONAL DRUG USE:

Do you drink alcohol?	NO	YES	Number of drinks per week: _____
Had you had a drink today:	NO	YES	If YES, how many? _____
Do you use recreational drugs?	NO	YES	If YES, what kind? _____
Have you used any recreational drugs today?	NO	YES	If YES, what? _____

ALLERGIES OR REACTIONS TO MEDICINES, FOODS, OR OTHER AGENTS: ❑None

Medication	Reaction or side effect	Medication	Reaction or side effect

PERSONAL MEDICAL HISTORY: List all significant diagnoses or illnesses and approximate dates or ages of onset. All medications entered above should correspond to a medical condition. ❑None

Medical condition	Date or age of onset

Do you have a history of any of the following:

YES NO Gastrointestinal bleeding, stomach ulcers or perforation

YES NO Heart attack, heart surgery, or stroke

YES NO Kidney disease or kidney failure

YES NO Bleeding disorders or bleeding complications

YES NO Taking any NSAIDs today? (aspirin, Ibuprofen, Advil, Aleve) If YES, has it been longer than 6 hrs? YES NO

YES NO Uncontrolled high blood pressure

YES NO Ever advised not to take NSAIDs

Do you give permission to have your photograph on social media? (Facebook, Instagram, The Drip Website) YES or NO

CANCELLATION POLICY. We require a 24-hour notice to reschedule. To receive a full refund, we require a 3-day notice for cancellation. If cancelled within 3 days, you will receive a credit for a future IV Infusion Treatment to be used within 90 days. If cancellation is same day or client no-shows, NO credit will be given for future treatment.

_____ _____

Client Signature Date