CONCIERGE iv MD
Recharge. Revitalize. Renew.

Questionnaire/Consent

Personal Information

Full Name: _____

Date of Birth: _____

Gender: ☐ Male ☐ Female ☐ Other: _____

Contact Number: _____

Emergency Contact (Name & Phone): _____

Infusion Contraindications: ☐ Allergy or hypersensitivity to product to be administered
☐ >85 years old ☐ Congestive heart failure ☐ Fluid retention ☐ Hemophilia
☐ Myasthenia Gravis ☐ History of uncontrolled bleeding
☐ Impaired medical decision making ☐ Pulmonary hypertension ☐ Heart Disease
☐ Kidney (renal) disease ☐ Liver disease ☐ Hereditary optic nerve atrophy

Health History

Do you have any known allergies?

☐ Yes ☐ No
If yes, please specify: _____

Have you ever had an adverse reaction to any IV therapy or infusions?
☐ Yes ☐ No
If yes, please provide details: _____

Do you have any chronic medical conditions? (e.g., diabetes, hypertension, etc.)
☐ Yes ☐ No
If yes, please list: _____

Are you currently taking any prescription medications?
☐ Yes ☐ No

If yes, please list all: _____

Do you have a history of heart, kidney, or liver disease?
☐ Yes ☐ No

If yes, please provide details: _____

Have you had any surgeries in the past?
☐ Yes ☐ No

If yes, please list: _____

Do you smoke, or have you ever smoked?
☐ Yes ☐ No

If yes, how long or how many cigarettes per day? _____

Do you drink alcohol?
☐ Yes ☐ No
If yes, how often? _____

Are you currently pregnant or breastfeeding?
☐ Yes ☐ No

Wellness and Lifestyle Information

What are your primary wellness goals for the IV infusion? (Select all that apply)

☐ Vitamin Boost – I want to enhance my energy, immune system, and overall vitality.

☐ Hangover Relief – I need support for dehydration, fatigue, and nausea after drinking.

☐ Anti-Aging – I'm looking to improve my skin, reduce wrinkles, and promote healthy aging.

☐ Hydration – I need to rehydrate and restore essential minerals.

☐ Other: _____

If you selected Vitamin Boost or Anti-Aging, are you experiencing any of the following symptoms?
☐ Fatigue ☐ Weak immune system ☐ Skin dullness ☐ Hair thinning ☐ Mood swings ☐ Brain fog ☐ Other: _____

If you selected Hangover Relief, how severe are your hangover symptoms typically?
☐ Mild ☐ Moderate ☐ Severe
(e.g., nausea, headache, fatigue, dehydration, etc.)

For Anti-Aging purposes, do you have any current skin concerns or goals?

☐ Wrinkle prevention ☐ Acne prevention ☐ Skin hydration ☐ Skin brightening ☐ Collagen production ☐ Other: _____

How often do you experience dehydration or low energy levels?

☐ Rarely ☐ Occasionally ☐ Frequently ☐ Constantly

How would you rate your stress and sleep quality in general?

☐ Low stress / Excellent sleep

☐ Moderate stress / Good sleep

☐ High stress / Poor sleep

☐ Other: _____

Infusion-Specific Questions

Hangover Relief (for alcohol recovery):

Have you experienced any of the following symptoms within 24 hours of drinking? (Select all that apply)

☐ Nausea ☐ Vomiting ☐ Fatigue ☐ Headache ☐ Dehydration ☐ Dizziness
☐ Muscle Aches ☐ Other: _____

For Vitamin Boost Infusion:

Are you interested in a specific vitamin (e.g., Vitamin C, B12, or a combination), or would you like a full-spectrum boost?

☐ Specific vitamin: _____ ☐ _____ m

Anti-Aging (skin and beauty-related):

Are you currently using any skincare products or treatments?

☐ Yes ☐ No

If yes, please describe: _____

Consent & Acknowledgment

By signing this form, I confirm that the information provided is accurate to the best of my knowledge. I acknowledge that the wellness IV infusion is a supportive treatment and not a substitute for medical care. I understand that any changes in my health status should be communicated to the healthcare provider.

Signature: _____

Date: _____