

NEW CLIENT HEALTH HISTORY

Please complete before your first visit

PERSONAL INFORMATION

Field	Answer
Full name	
Date of birth	
Phone and email	
Address	
Emergency contact (name, relationship, phone)	
Primary care provider (name, phone)	
How did you hear about us?	

REASON FOR VISIT

What are you hoping to achieve? _____

HEALTH SCREENING

Do you have, or have you ever had, any of the following? Circle yes or no.

Condition	Yes / No	Details
Heart disease, heart failure, or irregular heartbeat	Yes / No	
High or low blood pressure	Yes / No	
Kidney disease or kidney stones	Yes / No	
Liver disease	Yes / No	
Diabetes	Yes / No	
Thyroid condition	Yes / No	
G6PD deficiency (or ever tested for it)	Yes / No	
Anemia or other blood disorder	Yes / No	
Bleeding or clotting disorder	Yes / No	
Iron overload (hemochromatosis)	Yes / No	
Lung condition (asthma, COPD)	Yes / No	
Seizures	Yes / No	
Cancer (current or past)	Yes / No	
Autoimmune condition	Yes / No	
Surgery in the past 6 months, or one planned	Yes / No	
Fainting or difficult IV starts in the past	Yes / No	
Lymph node removal, port, fistula, or an arm to avoid	Yes / No	
Pregnant, breastfeeding, or trying to conceive	Yes / No	
Prior reaction to IV therapy or injections	Yes / No	
Other: _____	Yes / No	
Other: _____	Yes / No	

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MEDICATIONS AND SUPPLEMENTS

List all prescription medications, hormone therapy, peptides, blood thinners, and supplements.

Name	Dose	How often

ALLERGIES

- ☐ No known allergies
☐ Medications: _____
☐ Latex or adhesives: _____
☐ Preservatives or sulfites: _____
☐ Other: _____

LABS

Question	Answer
Date of most recent bloodwork	
Any upcoming bloodwork? (date)	
Willing to share recent lab results?	Yes / No

LIFESTYLE

Question	Answer
Alcohol (drinks per week)	
Tobacco or nicotine use	
Caffeine (cups per day)	
Exercise (days per week)	

ACKNOWLEDGMENT

The information above is complete and accurate to the best of my knowledge. I will tell Ahn Point Wellness about any changes to my health, medications, or pregnancy status. I acknowledge receipt of the practice's Notice of Privacy Practices.

Patient signature: _____ **Date:** _____

Office use: Reviewed by (RN): _____ **Date:** _____ Routed to Dr. Ahn: ☐ Yes ☐ Not needed

MEDICAL GRADE IV, IM, AND SQ THERAPY

Informed Consent

Patient name: _____ Date of birth: _____

PURPOSE OF THERAPY

Medical grade IV therapy administers fluids, vitamins, minerals, amino acids, antioxidants, nicotinamide adenine dinucleotide (NAD+), and/or medications directly into the bloodstream to support hydration, nutrition, and overall wellness. IM and subcutaneous (SQ) injections deliver nutrients into muscle or under the skin, including take-home SQ injections I may give myself after instruction. Every treatment is ordered by Dr. Lynne Ahn after review of my health history and is administered by a registered nurse.

POTENTIAL BENEFITS

- Rapid and increased absorption of nutrients and medications
- Enhanced hydration
- Potential symptom relief (for example, fatigue, dehydration, or nausea)

These therapies support general wellness. They are not intended to diagnose, treat, cure, or prevent disease, and they do not replace care from my primary care provider. Some ingredients are prepared by licensed compounding pharmacies and are not FDA-approved for the wellness uses offered.

POSSIBLE RISKS AND SIDE EFFECTS

Medical grade IV therapy is generally safe. Potential risks and side effects include, but are not limited to:

- **Occasionally:** bruising, redness, or swelling at the IV or injection site; warmth, flushing, or a metallic taste; urine color changes from B vitamins.
- **Rarely:** infection, infiltration, allergic reactions to the administered substances, vein inflammation (phlebitis), medication interactions, dizziness, nausea, shortness of breath, feeling flushed, or fainting.
- **Extremely rare but serious:** severe allergic reactions including anaphylaxis, air embolism, venous thrombosis, nerve injury, fluid overload, and death.

Ingredient	What to know
High-dose vitamin C	Can cause red blood cell breakdown in people with G6PD deficiency, so screening may be required. May raise kidney stone risk. Can falsely raise some fingerstick glucose readings.
NAD+	Can cause flushing, chest tightness, nausea, or cramping if infused too quickly. It is given slowly and can be paused at any time.
Magnesium	Can cause warmth, flushing, or lower blood pressure.
Alpha-lipoic acid (ALA)	Can lower blood sugar. Tell your nurse if you have diabetes or take glucose-lowering medication.
Biotin	High doses can interfere with lab tests (thyroid, hormone, and cardiac tests). Tell your provider before any bloodwork.
Zinc	Can cause nausea or a metallic taste.
Glutathione and amino acids	Rare allergic reactions.

ALTERNATIVES

Alternatives include oral supplements, dietary and lifestyle changes, care from my primary care provider, or no treatment.

MEDICAL GRADE IV, IM, AND SQ THERAPY

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PATIENT ACKNOWLEDGMENTS AND CONSENT

1. I understand the nature of medical grade IV, IM, and SQ therapy, and the substances being administered have been explained to me. _____ (initial)
2. I am aware that other unforeseen complications outside of those listed above may occur. _____ (initial)
3. The benefits, risks, side effects, and alternatives have been explained to me, including the ingredient-specific risks above. _____ (initial)
4. I have disclosed all relevant medical history, including allergies, current medications, current supplements, and any pre-existing health conditions, including pregnancy or breastfeeding, to my healthcare provider. I will tell the clinic if anything changes. _____ (initial)
5. I understand that while medical grade IV therapy is provided to support my health, no specific outcome or cure is guaranteed. _____ (initial)
6. I understand that I have the right to ask questions about the procedure and substances being administered, and can withdraw my consent or stop treatment at any time. _____ (initial)
7. I understand that I may not receive treatment if I am intoxicated or under the influence of any illicit drugs. _____ (initial)
8. I will tell the nurse right away if I feel unwell during or after treatment. If an adverse reaction occurs, clinic staff will provide appropriate care, which may include calling 911 and transfer to a hospital. _____ (initial)
9. For take-home SQ injections, I have received instruction on safe injection, storage, and sharps disposal, and will contact the clinic with any reaction. _____ (initial, if applicable)

Consent: I, _____ (patient name), consent to the administration of medical grade IV therapy, IM and SQ injections, vitamins, and/or medications as ordered by Dr. Ahn. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. This consent is valid for 12 months or until my health status changes.

Patient signature: _____ **Date:** _____

Provider/witness signature: _____ **Date:** _____