IV Lounge by Injected Artistry
SEMAGLUTIDE WEIGHT LOSS PACKAGE

Name:_____ D.O.B._____
Phone._____ Email:_____
Address:_____City:_____State: _____
Zip code:_____

In case of an emergency, please contact:
Name: _____Relationship:_____
Phone: _____

Primary Physician:_____

Are you under the care of a physician other than primary care? **Y/N**

SEMAGLUTIDE WEIGHT LOSS MEDICATION

Semaglutide is a modified molecule our bodies make, called GLP-1. This medication is sold under the brand name of Ozempic and Wegovy. It is an anti-diabetic medication used to treat type II diabetes, reduce cardiac related diseases and it also may be used as an anti-obesity medication for long-term weight management.

SEMAGLUTIDES ACT IN THE FOLLOWING WAYS

- Delays how quickly our stomachs digest food. Leading to a feeling of fullness and satisfaction with smaller meal sizes
- Lowers blood sugars, in part by reducing the production of sugar in the liver
- Stimulates insulin secretion by the pancreas when blood sugar levels are high
- Targets areas in the brain that regulate appetite and food intake.

Indications for use (can be one or multiple indications):

1. BMI above healthy range
2. Type 2 diabetic
3. CAD
4. HTN
5. High LDL (or) low HDL (or) increased triglycerides
6. At least one weight-related disease

SIDE EFFECTS OF TAKING SEMAGLUTIDE INCLUDE BUT MAY NOT BE LIMITED TO:

1. Nausea
2. Muscle loss

3. Belching
4. Bloated
5. Excess air or gas in the stomach
6. Heartburn
7. Fever
8. yellow eyes or skin

Initial that you understand side effects (_____)

PRECAUTIONS WITH THE USE OF SEMAGLUTIDE

1. certain eye problems aka: diabetic retinopathy
2. disease of the pancreas aka: pancreatitis
3. Gallbladder disease
4. Kidney problems
5. Stomach or intestinal disorders aka: gastro paresis or digestive problems
6. Thyroid Disease- **this does not include high or low thyroid levels**

Initial that you understand precautions of using this medication (_____)

STRICT CONTRAINDICATIONS FOR THE USE OF SEMAGLUTIDE

1. Personal or family history of Medullary thyroid cancer
2. Multiple endocrine neoplasia
3. Type 1 diabetic
4. Pregnancy
5. Allergy to any of the ingredients (semaglutide) or (B-Vitamins)

Initial that you understand strict contraindications and acknowledge you do not have any of these medical conditions (_____)

HEALTH PROFILE

The purpose of the health profile is to determine a client's health status in order to guide his or her weight loss plan. A client may be advised to seek medical advice based on their health profile. The profile must be completed prior to beginning a weight loss program with IV Lounge by Injected Artistry.

Height:_____ Current Weight:_____
Minimum adult weight:_____Maximum adult weight:_____

PLEASE LIST ALL YOUR MEDICATIONS & SUPPLEMENTS

_____

_____

_____

DIABETES

Do you have diabetes: **Y/N** Type I Type II
Type II – Non-insulin-dependent (diabetic pills)
Type II – Insulin-dependent (diabetic pills and insulin)

CARDIOVASCULAR FUNCTION

Have you had any of the following conditions?
Arrhythmia: **Y/N** High potassium: **Y/N** Low potassium: **Y/N**
Coronary Artery Disease: **Y/N** High Blood Pressure: **Y/N**
Heart Attack: **Y/N** Blood Clots: **Y/N** Pulmonary Embolism: **Y/N**
Heart Valve Problems: **Y/N** Stroke: **Y/N** Heart attack: **Y/N**
If yes:_____

KIDNEY FUNCTION

Chronic Kidney Disease: **Y/N** Kidney Stones: **Y/N**
Kidney Transplant:**YN** Gout: **Y/N**
If yes:_____

LIVER FUNCTION

Any liver conditions: **Y/N** Gallstone issues: **Y/N**
If yes:_____

GASTROINTESTINAL FUNCTION

Constipation: **Y/N** Diverticulitis: **Y/N** Chron's : **Y/N** Reflux or GERD: **Y/N**
Irritable Bowel Syndrome: **Y/N** Ulcerative Colitis: **Y/N**
Regular Diarrhea: **Y/N** Bariatric Surgery: **Y/N** Date of surgery: _____
If yes:_____

NEUROLOGICAL & EMOTIONAL HEALTH

Alzheimer's Disease: **Y/N** Anorexia, Bulimia Or any Eating Disorder: **Y/N**
Depression: **Y/N**
If yes:_____

GENERAL HEALTH

Are you Pregnant or breastfeeding: **Y/N** Anxiety: **Y/N** Epilepsy: **Y/N**
Bipolar disorder: **Y/N** Do you have any other health issues: **Y/N**
Do you have food allergies: **Y/N**
If yes:_____

EATING HABITS

BREAKFAST:_____

LUNCH:_____

DINNER:_____

SNACKS:_____

BEVERAGES:_____

How much water do you drink in a day?_____

How much coffee or tea do you drink in a day?_____

How much Alcohol do you drink in a day?_____

Do you smoke? _____

YOUR SIGNATURE STATING THAT YOU UNDERSTAND ALL INFORMATION.
YOUR 100% COMMITMENT TO LOVING & HONORING YOUR BODY.

I confirm that the information that I have provided to IV Lounge by Injected Artistry is true, complete, and accurate and that I have not withheld or otherwise omitted, whether in whole or in part, any information concerning my health status. In this respect , I confirm that I have disclosed all past and present physical and or mental health issues or concerns that I have experienced, including diagnoses, or surgeries that I have had. Medications and supplements that are prescribed or that you take. (_____)

I understand that if I have not disclosed medical information to IV Lounge by Injected Artistry and I chose to follow the Weight Loss Protocol provided by IV Lounge by Injected Artistry, such decisions will be completely voluntary. Also, I release Jamie Slovenski RN, Ken Starr MD and all team members of IV Lounge by Injected Artistry and Ken Starr MD wellness from any & all damages, liability, claims and causes of action of any nature whatsoever that may result from such voluntary and informed decision of this weight loss program provided by IV Lounge by Injected Artistry. (_____)

By signing this contract I am Agreeing to release all medical malpractice. I Choose to have any issues decided by neutral arbitration and I am giving up my right to jury or court trial. The

weight loss program has been thoroughly explained to me and I have had opportunities to ask any questions or express any concerns and these questions or concerns have been answered to my satisfaction. (_____)

I am committed to a **once a week on the same day of each week for the entire program**. If you miss a day there are **no refunds**. (_____) Please let me know if you will be out of town the week before so I can arrange other options.
I have read and fully understood these risks completely give my consent for treatment of Semaglutide.

Print First & Last Name: _____
Date:_____

Signature: _____

COST OF TREATMENT:

$500 PER MONTH (4 DOSES) (_____)

Enclosed are thoughtful questions to help you bring awareness to your patterns and habits related to your body and mind. Awareness of these patterns will lead to changing, letting go, or adding healthy habits that lead you to a lifetime of success with your body and your mindset.

Our goal is to encourage you through this journey of self love and self worth! It is not about the food. Eating for nutrition and health will happen when you understand how you eat and how it is directly related to your self worth. Also, learning how to navigate stress and honoring who you are is the key to your body's health.

STACKING HEALTHY HABITS AND LOVING THIS WAY OF LIFE IS WHAT WE WANT FOR YOU.

Initial that you received the questions to ponder and that you will commit to yourself to look at these questions and take them into consideration to help you develop new healthy habits. (_____)

QUESTIONS FOR YOU TO PONDER:

Do you exercise?

What form of exercise do you enjoy?

Do you smoke cigarettes?

How often do you exercise?

How does exercise make you feel?

If you don't exercise how do you feel?

Do you follow a diet?

What will set you up for success to commit to having the body you want?

How is your sleep?

What is your morning routine? This is important because your morning routine will set you up for success for the rest of the day.

How much stress are you feeling?

What tools do you use to destress and have peace?

Besides food, what would make the biggest difference to lose extra weight and feel fabulous?

What are 3 things you love about yourself? What are 3 things that you would like to improve?

What patterns are you aware of that keep you stuck in not achieving your weight goals?

Do you have healthy food available for your meals or snacks?

Do you meal prep?

Do you cook?

Do you eat differently with friends or family?

Do you eat differently during holidays, vacations, at restaurants or any celebration?

How is your gut health? Regular bowel movements? Have you taken Antibiotics in the past year? When do you get bloated? Are you gassy or do you feel lethargic after eating?

How much sugar do you eat?

How much alcohol do you drink?

How often do you go out to eat?

What food makes you feel great: energy- light- no bloating?

What food makes you bloated or makes you tired and sleepy?

Is there a time you were super happy with your body and never worried about your weight?

What age did you start gaining weight?

What things do you do that make you feel amazing about your health and body?

What are 3 things you love about yourself?

What is the root cause of you gaining weight?

If you said to heck with it, and wanted to escape or destress or just eat the refrigerator, what would you eat and how much?

Would you feel satisfied or feel self loathing?

What would you do the next morning and how would you feel?
(This will say a lot about your patterns and how to prevent this self destructive behavior)

What exactly do you want your body to look and feel like? Don't hold back.

What are you holding onto that needs to be released? That doesn't serve you or keep you protected anymore?