IV THERAPY INTAKE FORM

Name: ____

Date of Birth: ___________________ Age: ________ Sex: M / F

Today's Date:__________________ Occupation: _______________________________________

Address, City, State, Zip code:

____

Phone:____________________________

Email address: ___________________________________

In case of emergency, please contact:

Name:____

Phone:____

How did you hear about us?___________________________

Which of the following pertain to today's visit? (Please check all that apply)

□ Fatigue or low energy

□ Stress

□ Poor diet due to busy lifestyle

□ Brain fog or trouble concentrating □ Low mood or depression

□ Headaches or migraines

□ Weight gain or difficulty losing weight □ Slow metabolism

□ Asthma and Allergies

□ Recent surgical procedure

□ Recent illness

□ Cold or flu symptoms

□ Dull or dry skin

□ Malabsorption issues

□ Cancer

□ Other____

Which statements best describe why you are here today? (Please check all that apply)

□ I want to have more energy and feel better overall

□ I want to do everything I can to nourish my body

□ I want to do everything I can to enhance my weight loss efforts

□ I want to prevent getting sick □ I want to recover quickly from my surgery or illness

□ I want to slow the aging process

□ I want to feel and look younger

□ I want to have smoother, brighter and more vibrant skin

□ I want to cleanse my body of toxins □ I want to recover quickly from a hangover

□ Other ____

(Females only) Are you pregnant or breastfeeding? Yes / No

Date of last labs or other lab testing _____________________

Have you ever been told that you have an electrolyte imbalance or other abnormal labs? (Please check all that apply)

□ Hypermagnesemia (High magnesium levels)

□ B12 deficiency

□ Vitamin D deficiency

□ Antioxidant deficiency such as Glutathione

□ Hypercalcemia (High calcium levels)

□ Hypokalemia (Low potassium levels)

□ Hemochromatosis (High iron levels)

□ Other _________________________

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

□ Blood pressure problems (High or low)

□ Heart Problems, if so, what type?

□ Stroke or “mini-stroke”

□ Kidney Problems

□ Diabetes (1 or 2?)

□ Kidney Stones

□ Autoimmune Condition(s)

□ Cancer

□ Sickle Cell Anemia

□ G6PD Deficiency

□ Parathyroid problems

□ Lyme Disease

Are you a smoker? Yes / No   If Yes, how much do you smoke and for how long?______________________

How many alcoholic drinks do you consume in a week? ____

Do you use any recreational drugs? Yes / No   If Yes, which ones and how often? _____________________

Prescription Medications – Strength – Frequency

____

____

____

Over the Counter Drugs – Strength – Frequency

____

____

____

Vitamins and Other Supplements – Strength – Frequency

____

____

____

Do you take Digoxin (Lanoxin) or Coumadin (Warfarin) for a heart problem? Yes / No

Do you take any diuretics or water pills? Yes / No If Yes, please list: ______________________________

Do you take any steroids, i.e. Prednisone? Yes / No If Yes, please list: ______________________________

Do you have any medication or food allergies? Yes / No If Yes, please list: ___________________________

List any other medical conditions you have (not mentioned above):

____
____
____

List of all surgical procedures you've had with approximate dates:

____
____
____

Is there anything else you'd like the provider to know?

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