IV Therapy Intake Form

Name:_____

Date of Birth:_____ Age:_____ Sex: M/F

Today's Date:_____ Occupation:_____

Address:

_____

Phone: (Cell or Home or Work): _____

Email Address: _____

In case of Emergency Contact:

Name: _____

Phone:_____

How did you hear about us?: _____

What are your Main Complaints? (Circle all that apply)

- Fatigue or Low Energy
- Stress
- Poor Diet due to busy Lifestyle
- Brain Fog
- Low Mood
- Depression
- Headaches or Migraines
- Weight Gain
- Slow Metabolism
-
- Allergies or Asthma
- Cold or Flu Symptoms
- Dull or Dry Skin
- Gastrointestinal Issues with Poor Absorption

Which Statements best Describe why you are here today? (Mark X by 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 rom my surgery or illness
- I want to slow aging process
- I want to feel and look younger
- I want smoother, brighter, and more vibrant skin
- I want to recover quickly from a hangover
- Other:_____

Date of your last Blood labs: _____

Where did you have these drawn? _____

FEMALES ONLY: Are you pregnant or are your breastfeeding? YES or NO.

Are you on your menstrual cycle? YES / NO

Have you every been told you have an electrolyte imbalance or other abnormal labs? (Please mark an X by all that apply)

- Hypermagnesemia (High Magnesium levels in blood)
- B12 Deficiency (low B12 in blood)
- Hypercalcemia (High Calcium in blood)
- Hypokalemia (Low Potassium Levels)
- Hemochromatosis (High Iron Levels)
- Other: _____

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? _____

Have you ever had alcoholic withdrawal? Shaking and Tremors?
_____

Do you use any recreational drugs? YES / NO. If Yes, Which ones and how often? _____

_____

Prescription Medications. Please list Strength and Frequency

_____

_____

_____

Over the Counter Drugs. Please list the Strength and Frequency

_____

_____

_____

Vitamins and Other Supplements. Please List the Strength and Frequency

_____

_____

_____

Do you take Digoxin (Lanoxing) or Coumadin (Warfarin) or other Blood Thinners? YES / NO

Do you take Diuretics or water pills? YES / NO

Do you have any Drug or Food Allergies? YES / NO

Do you have a Personal or a Family history of any of the Following:
If Yes, please list what the problem is….

- High or Low Blood Pressure
- Heart Problems
- Stroke or Mini Strokes
- Kidney Problems
- Bleeding disorder
- Kidney Stones
- Autoimmune Conditions
- Cancer
- Sickle Cell Anemia
- G6PD deficiency
- Parathyroid Problems

List any other Medical Conditions you have not mentioned above

_____

_____

_____

List all Surgical Procedures you have had with dates.

_____

_____

_____

Is there anything else you would like the Physician and Nurse to know?

_____

_____

_____

Have you every passed out getting your blood draw or at the sight of needles? YES / NO

Have you eaten in the past 1-2hrs? YES / NO
What did you eat? And When?

_____

Are you dehydrated for any reason? YES / NO