NAD+/IV Nutrient Therapy Questionnaire - Southern California

Please complete this online form and click "Send Form" at the end to send to our secure server.

** ALL RED STARRED QUESTIONS MUST HAVE AN ANSWER (write "None" if applicable) OR ELSE THE QUESTIONNAIRE WILL NOT BE PROCESSED THROUGH THE SYSTEM **
* Required

1. Email address *

_____

2. How did you find out about Klarity Clinic? *

Mark only one oval.

- ◯ Referred by a health care provider
- ◯ Referred by friends or family
- ◯ Google or other web search
- ◯ Facebook or other social media
- ◯ Yelp
- ◯ Radio
- ◯ Magazine or print media
- ◯ Television/News
- ◯ Other: _____

Contact Information

3. First Name *

_____

4. Last Name *

5. Date of Birth *

Example: January 7, 2019

6. Phone *

7. Home Address *

8. City/State/Zip *

9. Primary Care Provider Name

10. Primary Care Provider Phone Number

11. Primary Care Provider Address

12. Principle Diagnosis and Other Diagnoses (What condition(s) are you seeking treatment for?) *

Medical History

13. What is your height? *

14. What is your weight? *

15. Medical Conditions

(Please check all that apply)

Check all that apply.

- [ ] High Blood Pressure
- [ ] Heart Disease
- [ ] Chest Pains / Angina
- [ ] Congestive Heart Failure
- [ ] Irregular Heart Rhythm
- [ ] Asthma
- [ ] Difficulty Exercising
- [ ] COPD/Emphysema/Chronic Bronchitis
- [ ] Using Home Oxygen
- [ ] Pulmonary Hypertension
- [ ] Diabetes
- [ ] Thyroid Problems
- [ ] Seizures
- [ ] Stroke / TIA
- [ ] Headaches
- [ ] Cognitive Problems
- [ ] Visions / Voices
- [ ] Dementia
- [ ] Dizziness / Fainting
- [ ] Numbness / Tingling
- [ ] Unsteady Gait
- [ ] Other Neurological Conditions
- [ ] Acid Reflux
- [ ] Abdominal Pain
- [ ] Nausea / Vomiting
- [ ] Other GI Conditions
- [ ] Chronic Pain
- [ ] Abnormal Bleeding / Clotting Disorder
- [ ] Anemia
- [ ] Kidney Problems
- [ ] Liver Problems
- [ ] Gynecologic Issues
- [ ] Muscle Disorders
- [ ] Bone / Joint Disorders
- [ ] Immunity Issues

- [ ] Infectious Diseases

16. Are you pregnant?

Mark only one oval.

- ◯ No
- ◯ Yes
- ◯ N/A

17. If not, when was your last menstrual period?

_____

Example: January 7, 2019

18. Breastfeeding

(If applicable, are you breastfeeding?)

Mark only one oval.

- ◯ No
- ◯ Yes

19. Please list any other medical conditions not noted above and/or explanations of the conditions above that you feel would be helpful for us to know.

_____

_____

_____

_____

_____

20. Current Medications *

21. Previous Surgeries *

22. Have you or your direct family members ever had a serious adverse reaction to anesthesia? *

Mark only one oval.

- No
- Yes

23. If so, what was the reaction and whom did it happen to?

24. Allergies *

25. Tobacco Use *

Mark only one oval.

- No
- Yes

26. Do you drink more than 2 alcoholic beverages per day? *

Mark only one oval.

- No
- Yes

27. Do you use recreational drugs? *

(If applicable, list drug and when last used)

28. Have you ever been treated for substance abuse?

(Please check all that apply)

Check all that apply.

- [ ] Drug
- [ ] Alcohol

Patient Attestation

By submitting this form, I certify that I have completed this Questionnaire to the best of my ability.

I agree to seek immediate help should my symptoms worsen or I experience an increase in suicidal thoughts, feelings or urges.

I authorize a representative from Klarity Clinic of Southern California to contact me to discuss treatment options for my condition(s). I also understand that the staff of Klarity Clinic of Southern California may not start and maintain any prescribed treatment regimen if I am not currently under the care of a Health Professional and maintain such care until the completion of my course of treatment. I also consent to receiving emails from Klarity Clinic for marketing purposes and I may opt out at anytime in the future by unsubscribing from Klarity's marketing list.