

NAD+/IV Nutrient Therapy Questionnaire - Denver

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 *

Contact Information

2. First Name *

3. Last Name *

4. Date of Birth *

Example: December 15, 2012

5. Phone *

6. Home Address *

7. City/State/Zip *

8. Primary Care Provider Name

9. Primary Care Provider Phone Number

10. Primary Care Provider Address

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

Medical History

12. What is your height? *

13. What is your weight? *

14. 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

15. Are you pregnant?

Mark only one oval.

- No
- Yes
- N/A

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

Example: December 15, 2012

17. Breastfeeding

(If applicable, are you breastfeeding?)

Mark only one oval.

- No
- Yes

18. 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.

19. Current Medications *

20. Previous Surgeries *

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

Mark only one oval.

- No
- Yes

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

23. Allergies *

24. Tobacco Use *

Mark only one oval.

- No
- Yes

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

Mark only one oval.

- No
- Yes

26. Do you use recreational drugs? *

(If applicable, list drug and when last used)

27. 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 Depression 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 Denver to contact me to discuss treatment options for my condition(s). I also understand that the staff of Klarity Clinic of Denver 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.

A copy of your responses will be emailed to the address you provided

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