IV THERAPY INTAKE FORM

GENERAL INFORMATION

TODAY'S DATE _____ HOW DID YOU HEAR ABOUT US? _____

FIRST NAME _____ LAST NAME _____

DATE OF BIRTH _____ AGE _____ GENDER: □ M ■ F

ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____

PHONE (HOME) _____ (CELL) _____ (WORK) _____

E-MAIL _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____

EMERGENCY CONTACT PHONE _____

WHAT ARE YOUR GOALS WITH NUTRITIONAL IV THERAPY?

1._____

2._____

GENERAL HEALTH

Are you currently seeing a physician for **any reason.** If yes, explain reason: □ Yes □ No

_____

Do you have any health problems? If yes, please list □ Yes □ No

_____

_____

Do you have any allergies or sensitivities? If yes, please list □ Yes □ No

_____

_____

Do you smoke?	□ Yes □ No	If yes, how much/often? _____
Do you consume alcohol?	□ Yes □ No	If yes, frequency/amount_____
Do you have a healthy diet?	□ Yes □ No	List any dietary concerns_____
Do you exercise?	□ Yes □ No	If yes, how often?_____ Type(s)_____
Do you take vitamins?	□ Yes □ No	If yes, what type(s)? _____
Do you drink water?	□ Yes □ No	If yes, how many glasses per day?_____

MEDICAL HISTORY

Illnesses/Conditions: ***Check appropriate Box: YES****-a condition you currently have,* ***PAST****-a condition you've had in the past*

Gastrointestinal	
Irritable Bowel Syndrome	☐ Yes ☐ Past
GERD (reflux)	☐ Yes ☐ Past
Crohn's Disease/Ulcerative Colitis	☐ Yes ☐ Past
Peptic Ulcer Disease	☐ Yes ☐ Past
Celiac Disease	☐ Yes ☐ Past
Gallstones	☐ Yes ☐ Past
Other:	☐ Yes ☐ Past
Respiratory	
Bronchitis	☐ Yes ☐ Past
Asthma	☐ Yes ☐ Past
Emphysema	☐ Yes ☐ Past
Pneumonia	☐ Yes ☐ Past
Sinusitis	☐ Yes ☐ Past
Sleep Apnea	☐ Yes ☐ Past
Other:	☐ Yes ☐ Past
Urinary/Genital	
Kidney Stones	☐ Yes ☐ Past
Gout	☐ Yes ☐ Past
Interstitial Cystitis	☐ Yes ☐ Past
Frequent Yeast Infections	☐ Yes ☐ Past
Frequent Urinary Tract Infections	☐ Yes ☐ Past
Sexual Dysfunction	☐ Yes ☐ Past
Sexually Transmitted Diseases	☐ Yes ☐ Past
Other:	☐ Yes ☐ Past
Endocrine/Metabolic	
Diabetes	☐ Yes ☐ Past
Hypothyroidism (low thyroid)	☐ Yes ☐ Past
Hyperthyroidism (overactive thyroid)	☐ Yes ☐ Past
Polycystic Ovarian Syndrome	☐ Yes ☐ Past
Infertility	☐ Yes ☐ Past
Metabolic Syndrome/Insulin Resistance	☐ Yes ☐ Past
Eating Disorder	☐ Yes ☐ Past
Hypoglycemia	☐ Yes ☐ Past
G6PD Marker	☐ Yes ☐ Past
Other:	☐ Yes ☐ Past
Inflammatory/Immune	
Rheumatoid Arthritis	☐ Yes ☐ Past
Chronic Fatigue Syndrome	☐ Yes ☐ Past
Food Allergies	☐ Yes ☐ Past
Environmental Allergies	☐ Yes ☐ Past
Multiple Chemical Sensitivities	☐ Yes ☐ Past
Autoimmune Disease	☐ Yes ☐ Past
Immune Deficiency	☐ Yes ☐ Past
Mononucleosis	☐ Yes ☐ Past
Hepatitis	☐ Yes ☐ Past

Other:	☐ Yes ☐ Past
Musculoskeletal	
Fibromyalgia	☐ Yes ☐ Past
Osteoarthritis	☐ Yes ☐ Past
Chronic Pain	☐ Yes ☐ Past
Other:	☐ Yes ☐ Past
Skin	
Eczema	☐ Yes ☐ Past
Psoriasis	☐ Yes ☐ Past
Acne	☐ Yes ☐ Past
Skin Cancer	☐ Yes ☐ Past
Other:	☐ Yes ☐ Past
Cardiovascular	
Angina	☐ Yes ☐ Past
Heart Attack	☐ Yes ☐ Past
Heart Failure	☐ Yes ☐ Past
Hypertension (high blood pressure)	☐ Yes ☐ Past
Stroke	☐ Yes ☐ Past
High Blood Fats (cholesterol, triglycerides)	☐ Yes ☐ Past
Rheumatic Fever	☐ Yes ☐ Past
Arrythmia (irregular heart rate)	☐ Yes ☐ Past
Murmur	☐ Yes ☐ Past
Mitral Valve Prolapse	☐ Yes ☐ Past
Other:	☐ Yes ☐ Past
Neurologic/Emotional	
Epilepsy/Seizures	☐ Yes ☐ Past
ADD/ADHD	☐ Yes ☐ Past
Headaches	☐ Yes ☐ Past
Migraines	☐ Yes ☐ Past
Depression	☐ Yes ☐ Past
Anxiety	☐ Yes ☐ Past
Autism	☐ Yes ☐ Past
Multiple Sclerosis	☐ Yes ☐ Past
Parkinson's Disease	☐ Yes ☐ Past
Dementia	☐ Yes ☐ Past
Cancer	
Lung	☐ Yes ☐ Past
Breast	☐ Yes ☐ Past
Colon	☐ Yes ☐ Past
Ovarian	☐ Yes ☐ Past
Prostate	☐ Yes ☐ Past
Skin	☐ Yes ☐ Past
Other:	☐ Yes ☐ Past

MEDICATIONS AND SUPPLEMENTS

Please list all current prescription medications, over the counter drugs, supplements, and vitamins you take regularly that were not previously listed in earlier sections. Please include any you have taken in the past 3 months.

Medication/OTC/Supplement	Dosage	Frequency	Last Taken

Have you ever had IV or injectable vitamin therapy? □ Yes □ No If yes, when? _____

Have you had prolonged or regular use of NSAIDs (Advil, Aleve, etc.) Motrin, Aspirin? □ Yes □ No

Have you had prolonged or regular use of Tylenol? □ Yes □ No

DIAGNOSTIC STUDIES

Please indicate if you have had any of the following diagnostic studies, providing dates and test results as applicable.

Diagnostic	Date	Results/Comments
Genetic Testing		
MicroNutrient Panel		
Vitamin D		
Vitamin B12		
Heavy Metals		
Organic Acids		
Food Sensitivities		
Neurotransmitter		
Cardio Panel		
Thyroid		
Sex Hormones		
Other:		

SYMPTOM REVIEW (Physiology and Function)

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis and treatment plan. Please indicate symptoms that occur presently or in the past six months by indicating their severity.

1 = Mild 2 = Moderate 3 = Severe

General	
Cold Hands and Feet	0 Non
Cold Intolerance	0 Non
Daytime Sleepiness	0 Non
Difficulty Falling Asleep	0 Non
Early Waking	0 Non
Fatigue	0 Non
Fever	0 Non
Flushing	0 Non
Heat Intolerance	0 Non
Night Waking	0 Non
Nightmares	0 Non
No Dream Recall	0 Non
Low Body Temperature	0 Non
Head, Eyes, and Ears	
Conjunctivitis	0 Non
Distorted Sense of Smell	0 Non
Distorted Taste	0 Non
Ear Fullness	0 Non
Ear Ringing/Buzzing	0 Non
Eye Crusting	0 Non
Eye Pain	0 Non
Headache	0 Non
Hearing Loss	0 Non
Hearing Problems	0 Non
Lid Margin Redness	0 Non
Migraine	0 Non
Sensitivity to Noises	0 Non
Vision Problems	0 Non
Musculoskeletal	
Back muscle spasm	0 Non
Calf cramps	0 Non
Chest tightness	0 Non
Foot cramps	0 Non
Joint deformity	0 Non
Joint pain	0 Non
Joint redness	0 Non
Joint stiffness	0 Non
Muscle pain	0 Non
Muscle spasms	0 Non
Muscle stiffness	0 Non
Muscle twitches:	0 Non
Around eyes	0 Non
Arms or legs	0 Non
Muscle weakness	0 Non
Neck muscle spasm	0 Non
Tendonitis	0 Non
Tension headache	0 Non
TMJ problems	0 Non

Mood/Nerves	
Agoraphobia	0 Non
Anxiety	0 Non
Auditory hallucinations	0 Non
Black-out	0 Non
Depression	0 Non
Difficulty:	
Concentrating	0 Non
With balance	0 Non
With thinking	0 Non
With judgment	0 Non
With speech	0 Non
With memory	0 Non
Dizziness (spinning)	0 Non
Fainting	0 Non
Fearfulness	0 Non
Irritability	0 Non
Light-headedness	0 Non
Numbness	0 Non
Other Phobias	0 Non
Panic attacks	0 Non
Paranoia	0 Non
Seizures	0 Non
Suicidal thoughts	0 Non
Tingling	0 Non
Tremor/trembling	0 Non
Visual hallucinations	0 Non
Cardiovascular	
Angina/chest pain	0 Non
Breathlessness	0 Non
Heart attack	0 Non
Heart murmur	0 Non
High blood pressure	0 Non
Irregular pulse	0 Non
Mitral valve prolapse	0 Non
Palpitations	0 Non
Phlebitis	0 Non
Swollen ankles/feet	0 Non
Varicose veins	0 Non
Urinary	
Bed wetting	0 Non
Hesitancy	0 Non
Infection	0 Non
Kidney disease	0 Non
Kidney stone	0 Non
Leaking/incontinence	0 Non
Pain/burning	0 Non
Prostate enlargement	0 Non
Prostate infection	0 Non
Urgency	0 Non

Digestion	
Anal spasms	0 Non
Bad teeth	0 Non
Bleeding gums	0 Non
Bloating of:	
Lower abdomen	0 Non
Whole abdomen	0 Non
Bloating after meals	0 Non
Blood in stools	0 Non
Burping	0 Non
Canker sores	0 Non
Cold sores	0 Non
Constipation	0 Non
Cracking at lip corners	0 Non
Dentures w/poor chewing	0 Non
Diarrhea	0 Non
Difficulty swallowing	0 Non
Dry mouth	0 Non
Farting	0 Non
Fissures	0 Non
Foods "repeat" (reflux)	0 Non
Heartburn	0 Non
Hemorrhoids	0 Non
Intolerance to:	
Lactose	0 Non
All dairy products	0 Non
Gluten (wheat)	0 Non
Corn	0 Non
Eggs	0 Non
Fatty foods	0 Non
Yeast	0 Non
Liver disease/jaundice	0 Non
Lower abdominal pain	0 Non
Lower abdominal pain	
Mucus in stools	0 Non
Nausea	0 Non
Periodontal disease	0 Non
Sore tongue	0 Non
Strong stool odor	0 Non
Undigested food in stools	0 Non
Upper abdominal pain	0 Non
Vomiting	0 Non
Respiratory	
Bad breath	0 Non
Bad odor in nose	0 Non
Cough - dry	0 Non
Cough - productive	0 Non
Hay fever:	
Spring	0 Non
Summer	0 Non

Fall	0 Non
Change of season	0 Non
Hoarseness	0 Non
Nasal stuffiness	0 Non
Nose bleeds	0 Non
Post nasal drip	0 Non
Sinus fullness	0 Non
Sinus infection	0 Non
Snoring	0 Non
Sore throat	0 Non
Wheezing	0 Non
Winter stuffiness	0 Non
Nails	
Bitten	0 Non
Brittle	0 Non
Curve up	0 Non
Frayed	0 Non
Fungus - fingers	0 Non
Fungus - toes	0 Non
Pitting	0 Non
Ragged cuticles	0 Non
Ridges	0 Non
Soft	0 Non
Thickening of:	
Finger nails	0 Non
Toenails	0 Non
White spots/lines	0 Non
Lymph Nodes	
Enlarged/neck	0 Non
Tender/neck	0 Non
Other enlarged/tender lymph nodes	0 Non
Eating	
Binge eating	0 Non
Bulimia	0 Non
Can't gain weight	0 Non
Can't lose weight	0 Non
Carbohydrate craving	0 Non
Carb intolerance	0 Non
Poor appetite	0 Non
Salt cravings	0 Non
Frequent Dieting	0 Non
Sweet Cravings	0 Non
Caffeine Dependency	0 Non

Skin Problems	
Acne on back	0 Non
Acne on chest	0 Non
Acne on face	0 Non
Acne on shoulders	0 Non
Athlete's foot	0 Non
Bumps on back of upper arms	0 Non
Cellulite	0 Non
Dark circles under eyes	0 Non
Ears get red	0 Non
Easy bruising	0 Non
Eczema	0 Non
Herpes - genital	0 Non
Hives	0 Non
Jock itch	0 Non
Lackluster skin	0 Non
Moles w color/size change	0 Non
Oily skin	0 Non
Pale skin	0 Non
Patchy dullness	0 Non
Psoriasis	0 Non
Rash	0 Non
Red face	0 Non
Sensitive to bites	0 Non
Sensitive to poison ivy/oak	0 Non
Shingles	0 Non
Skin cancer	0 Non
Skin darkening	0 Non
Strong body odor	0 Non
Thick calluses	0 Non
Vitiligo	0 Non
Itching Skin	
Anus	0 Non
Arms	0 Non
Ear canals	0 Non
Eyes	0 Non
Feet	0 Non
Hands	0 Non
Legs	0 Non
Nipples	0 Non
Nose	0 Non
Penis	0 Non
Roof of mouth	0 Non
Scalp	0 Non
Skin in general	0 Non
Throat	0 Non

Skin, Dryness of	
Eyes	0 Non
Feet	0 Non
Any cracking?	0 Non
Any peeling?	0 Non
Hair	0 Non
And unmanageable?	0 Non
Hands	0 Non
Any cracking?	0 Non
Any peeling?	0 Non
Mouth/throat	0 Non
Scalp	0 Non
Any dandruff?	0 Non
Skin in general	0 Non
Male Reproductive	
Discharge from penis	0 Non
Ejaculation problem	0 Non
Genital pain	0 Non
Impotence	0 Non
Infection	0 Non
Lumps in testicles	0 Non
Poor libido (sex drive)	0 Non
Female Reproductive	
Breast cysts	0 Non
Breast lumps	0 Non
Breast tenderness	0 Non
Ovarian cyst	0 Non
Poor libido (sex drive)	0 Non
Endometriosis	0 Non
Fibroids	0 Non
Infertility	0 Non
Vaginal discharge	0 Non
Vaginal odor	0 Non
Vaginal itch	0 Non
Vaginal pain	0 Non
Premenstrual:	
Bloating	0 Non
Breast tenderness	0 Non
Carbohydrate craving	0 Non
Chocolate craving	0 Non
Constipation	0 Non
Decreased sleep	0 Non
Diarrhea	0 Non
Fatigue	0 Non
Increased sleep	0 Non
Irritability	0 Non
Menstrual:	
Cramps	0 Non
Heavy periods	0 Non
Irregular periods	0 Non
No periods	0 Non
Scanty periods	0 Non
Spotting between	0 Non

ENVIRONMENTAL/DETOXIFICATION HISTORY

Do any of these significantly affect you? □ Cigarette Smoke □ Perfume/Colognes
□ Auto Exhaust Fumes □ Other: _____

Do you have regular exposure to any of the following: *(check all that apply)*

□ Mold	□ Water leaks	□ Renovations	□ Old paint
□ Paints	□ Damp environments	□ Carpets or rugs	□ Herbicides
□ Pesticides	□ Regular contact with smokers	□ Cleaning chemicals	□ Airplane travel
□ Stagnant or stuffy air	□ Electromagnetic Radiation	□ Harsh chemicals (solvents, glues, acids, etc)	
□ Heavy metals (lead, mercury, etc)		□ Other: _____	

Is there history of a significant exposure to any harmful chemicals? □ Yes □ No

If yes: Chemical name, length of exposure, date:

_____

Do you have any pets or farm animals? □ Yes □ No If yes, where do they live? □ Inside □ Outside □ Both

NUTRITION

Please tell us about your dietary habits.

Do you feel you have a healthy diet and eating habits? □ Yes □ No

Do you currently follow any of the following special diet or nutritional program? Check all that apply

□ Vegetarian	□ Vegan	□ Allergy	□ Elimination	□ Low Fat
□ Low Carb	□ High Protein	□ Blood Type	□ Low sodium	□ No Dairy
□ No Wheat	□ Gluten Free	□ Other: _____		

How many meals do you eat a day, including snacks? □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 or more

ACKNOWLEDGEMENTS AND CONSENT

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initial

____ I instruct the health care practitioner to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the health care offered in this practice is based on the best available evidence.

____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

____ **My primary physician has medically cleared me with todays IV vitamin infusion therapy.**

Patient Signature: _____ Date: _____