Intake Questionnaire

Date: ___________________________

Name: _______________________________ DOB:___________ Age: ________

Address:
____
____

Phone: _____________________Email: ___________________________________

Reason for visit:
____

Emergency Contact:
____

Please briefly describe why you are seeking IV infusion or injection therapy? For example: Are you looking to improve your energy, skin/hair/nail quality, recovery times, immune system, or hydration status? Are you seeking treatment for a hangover or looking to feel and look better?
____
____
____
____
____

Allergies (Medications, foods, etc.):
____
____
____

Intake Questionnaire

Current Medications: (Please include OTC & supplements)
____
____
____
____

Please circle any conditions that apply to you:

CARDIOVASCULAR AND RESPIRATORY

- High Blood Pressure
- Heart Murmur
- Valve Disorder
- Abnormal Rhythm
- Chest Pain
- Heart Attack
- Cardiac Surgery or Stents
- Congestive Heart Failure
- Peripheral Artery Disease
- Thrombosis or DVT
- Aneurysm

Asthma
COPD
Sleep Apnea
Shortness of Breath
Pulmonary Hypertension
Lung Cancer
Other Lung Disorder ________________________
Other Cardiac Disorder ______________________

GASTROINTESTINAL AND URINARY

- Acid Reflux
- Bladder Disease
- Kidney Disease

Liver Disease
Hepatitis A, B, C
Other ___________________________

METABOLIC/ENDOCRINE/AUTOIMMUNE

- Hyper/Hypo Thyroid
- Diabetes Type I Type II
- Lupus

Rheumatoid Arthritis
Hx of DKA
Other ________________________

NEUROLOGIC

- Stroke/TIA

Intake Questionnaire

- Multiple Sclerosis
- Seizures – date of last seizure _______________

Parkinson's
Alzheimer's

HEMATOLOGY

- Anemia (Iron Deficiency, Pernicious, Aplastic, Hemolytic, Sickle Cell)
- MTHFR
- G6PD Deficiency

MUSCULOSKELETAL

- Back Pain
- Carpal Tunnel Syndrome
- Fibromyalgia

Degenerative Joint Disease
Degenerative Disk Disease
Other_________________________

PSYCHOLOGICAL

- Depression
- Anxiety or Panic Attacks

Suicidal Ideations

CANCER

Location of cancer _____________________________
Chemotherapy
Radiation

WOMEN (non-menopausal)

Last Menstrual Period _____________
Any chance that you are pregnant? ______
Are you currently breastfeeding? _________

PAIN

CRPS
Fibromyalgia

Do you drink alcohol or abuse any types of drugs? If so, please explain:
____
____
____

Intake Questionnaire

Have you ever had an electrolyte or fluid imbalance in the past? Such as low potassium, high sodium, etc.?

____
____
____
____

Would you like to tell us anything else that you feel like is important?

____
____
____
____

I attest that the information I have provided is true and accurate to the best of my knowledge:

____

Signature Date

____

Print name