INTRAVENOUS (IV) INFUSION THERAPY INTAKE FORM

Name ____ Nickname_____________Birthday ________________

Address _______________________________________ City, State, Zip_______________________ Sex ❑ M ❑ F

SS #___________________ Marital Status ❑ M ❑ D ❑ S ❑ W Spouse's Name__________________________

Home ❑____________ Work ❑____________Cell ❑____________ Email ❑__________________________ ✓Preferred

Occupation_____________________________ Employer ____

How did you hear about us? ❑ Internet ❑ Facebook ❑ Walk-in ❑ Friend ❑ Other ____________________________

What are your main complaints? (Please check all that apply)

❑ Fatigue or low energy
❑ Stress
❑ Poor diet due to busy lifestyle
❑ Brain fog or trouble concentrating
❑ Low mood or depression
❑ Headaches or migraines
❑ Weight gain or difficulty losing weight
❑ Slow metabolism
❑ Other ______________________
❑ Asthma and Allergies
❑ Recent surgical procedure
❑ Recent illness
❑ Cold or flu symptoms
❑ Facial wrinkles or fine lines
❑ Dull or dry skin
❑ Malabsorption issues

Which statements best describe why you are here today? (Please check 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 from my surgery or illness
❑ I want to slow the aging process
❑ I want to feel and look younger
❑ I want to have smoother, brighter and more vibrant skin
❑ I want to cleanse my body of toxins
❑ I want to recover quickly from a hangover
❑ Other _______________________________________

MEDICAL HISTORY

Are you pregnant or breastfeeding? Yes / No

Date of last chemistry screen or other lab testing ______________________

Have you ever been told that you have an electrolyte imbalance or other abnormal labs?

(Please check all that apply)

- ❑ Hypermagnesemia (High magnesium levels)
- ❑ Hypercalcemia (High calcium levels)
- ❑ Hypokalemia (Low potassium levels)
- ❑ Hemochromatosis (High iron levels)
- ❑ Other ___________________________

Are you a diabetic? Yes / No

Are you a smoker? Yes / No

If Yes, how much do you smoke? _________________________________

How many alcoholic drinks do you consume in a week? ____

Do you use any recreational drugs? Yes / No

If Yes, which ones and how often? ____

Please list everything you are currently taking:

Prescription Medications – Strength – Frequency – Condition being treated

____
____
____

Over the Counter Drugs – Strength – Frequency – Condition being treated

____
____
____

Vitamins and Other Supplements – Strength – Frequency – Condition being treated

____
____
____

Name and DOB: ____

Do you take Digoxin (Lanoxin) for a heart problem? Yes / No

Do you take any diuretics or water pills? Yes / No If Yes, please list: ____________________________

Do you take any steroids, i.e., Prednisone? Yes / No If Yes, please list: ____________________________

Do you have any medication or food allergies? Yes / No If Yes, please list: ____________________________

Do you have any of the following conditions? (Please check all that apply)

- ❑ Blood pressure problems (High or low)
- ❑ Heart Problems
- ❑ Stroke or “mini-stroke”
- ❑ Kidney Problems
- ❑ Kidney Stones
- ❑ Asthma
- ❑ Optic Nerve Atrophy or Leber’s Disease
- ❑ Sickle Cell Anemia
- ❑ G6PD Deficiency
- ❑ Sarcoidosis
- ❑ Parathyroid problems (High levels)

List any other medical conditions you have (not mentioned above):

____
____
____

List of all surgical procedures you have had with approximate dates:

____
____
____

Is there anything else you would like the nurse and physician to know?

____
____
____
____

Name and DOB: ____

IV Infusion Form

Date: ___________________________

Patient Name: _______________________________ DOB: ___________________________

Address: ____

Phone #: _______________________________________ Email: _______________________________

Current Medications: ____

____

Last set of labs: ____

Allergies: ____

Past Medical History – ***Have you ever been diagnosed with:***

_____	Hypertension	_____	Angina/Chest Pain	_____	Swelling
_____	Arrhythmia	_____	CHF	_____	MI (Heart attack)
_____	Abnormal EKG	_____	Kidney disease	_____	Blood/bleeding disorder
_____	Sudden weight loss	_____	Diabetes	_____	Anxiety/Panic Attack
_____	G6PD	_____	Leber's Disease	_____	Liver Disease
_____	Cancer	Females – Could you be pregnant?		Yes	No

Allergy to:

Latex? _________Shellfish? _________Iodine? _________Cobalt? __________ Vitamins? __________

Dye/Food Preservatives? __________ Gluten Allergy? __________ Milk Allergy? __________

Presence of Edema? ______________