

## 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much/often? _____
Do you consume alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, frequency/amount _____
Do you have a healthy diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	List any dietary concerns _____
Do you exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often? _____ Type(s) _____
Do you take vitamins?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type(s)? _____
Do you drink water?	<input type="checkbox"/> Yes <input type="checkbox"/> 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*

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

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

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

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

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

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

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

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

## **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*)

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Mold                              | <input type="checkbox"/> Water leaks                  | <input type="checkbox"/> Renovations                                   | <input type="checkbox"/> Old paint       |
| <input type="checkbox"/> Paints                            | <input type="checkbox"/> Damp environments            | <input type="checkbox"/> Carpets or rugs                               | <input type="checkbox"/> Herbicides      |
| <input type="checkbox"/> Pesticides                        | <input type="checkbox"/> Regular contact with smokers | <input type="checkbox"/> Cleaning chemicals                            | <input type="checkbox"/> Airplane travel |
| <input type="checkbox"/> Stagnant or stuffy air            | <input type="checkbox"/> Electromagnetic Radiation    | <input type="checkbox"/> Harsh chemicals (solvents, glues, acids, etc) |  |
| <input type="checkbox"/> Heavy metals (lead, mercury, etc) | <input type="checkbox"/> 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

- |                                     |                                       |                                       |                                      |                                   |
|-------------------------------------|---------------------------------------|---------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Vegan        | <input type="checkbox"/> Allergy      | <input type="checkbox"/> Elimination | <input type="checkbox"/> Low Fat  |
| <input type="checkbox"/> Low Carb   | <input type="checkbox"/> High Protein | <input type="checkbox"/> Blood Type   | <input type="checkbox"/> Low sodium  | <input type="checkbox"/> No Dairy |
| <input type="checkbox"/> No Wheat   | <input type="checkbox"/> Gluten Free  | <input type="checkbox"/> 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.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_