3636 5th Avenue San Diego, CA 92103

IV THERAPY INTAKE FORM

BASIC 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

_____

_____

- o Severe frequent headaches
- o Fainting/ seizures/ epilepsy
- o Diabetes/ low blood sugar
- o Any liver conditions (liver cirrhosis, hepatitis)
- o Asthma or lung disease
- o Bleeding disorder
- o G6PD deficiency
- o Anxiety or panic attacks
- o High Blood Pressure
- o Any problems with kidneys
- o Any other condition not listed:

Have you ever had IV or injectable vitamin therapy? □ Yes □ No

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

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.

Patient Signature: _____ Date: _____