IV Therapy Intake Form

Today's Date______________ How Did You Hear About Us?________________________________

First Name_________________________ Last Name____

Date of Birth__________________ Age____________ Gender________________________________

Address____

City_________________________________ State______________ Zip Code____________________

Phone (Home/ Cell)___________________________ Email __________________________________

Best way to contact: phone (home / cell), text, email

Emergency Contact Name _____________________________ Relationship____________________

Emergency Contact Phone ____________________________ Ok to share information: Yes/ No

What Are Your Goals with Nutritional IV Therapy?

1.____

2.____

General Health

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

____

Do you have any health problems? If yes, please explain: Yes / No

____

____

Have you ever had surgery? If yes please explain surgery and approximate year: Yes/ No

____

Does anything run in the family that is of concern to you? If yes, please explain: Yes / No

____

Do you have any allergies or sensitivities? If yes, please list and explain reaction: Yes / No

____

Have you had any significant exposure to toxins/chemicals/radioactivity? Yes / No

____

____

Do you smoke? Yes / No If yes, how much/ often?______________________

Do you consume alcohol? Yes / No If yes, what kind?/ how often?_________________

Do you have a healthy Diet? Yes / No Any dietary concerns__________________________

Do you exercise? Yes / No What type? How often?_______________________

Do you take vitamins? Yes / No if yes, what kind? ____________________________

Do you drink water? Yes / No If yes, how many glasses a day?_______________

Are you pregnant, planning to be pregnant, or nursing? Yes / No / NA

Anything else you feel is important about your health?___________________________________

____

____

Current Medications / Supplements (dosages, frequency, indication):

____

____

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

Have you ever had prolonged or regular use of NSAIDs (Advil, Aleve, Motrin, Aspirin)? Yes / No

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

Any significant Laboratory or Imaging studies that have suggested disease? Yes / No

Explain ____

____

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.

_____ 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 the the health care offered in this practice is based on the best available evidence and is not proven to cure disease.

_____ 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.

Risks and Side Effects

The procedure involves inserting a needle into the vein and keeping an IV catheter in the vein during the entirety of the infusion. The vitamin/mineral solution is infused into the body over a prescribed amount of time. Staff will monitor your vital signs, the injection site, and for any signs or symptoms of reaction.

______ Some side effects of an infusion are:

- Discomfort, pain, or bruising at the injection site.
- Inflammation of the vein used for injection, metabolic disturbances, and injury.
- In extremely rare cases: severe reaction, anaphylaxis, cardiac arrest, or death.

Benefits to intravenous therapy:

- Injections are not affected by the stomach or intestinal absorption issues.
- Nutrients are more bioavailable to tissues and organs than other routes of administration.

Alternatives to intravenous nutrition infusion:

- Oral supplements.
- Lifestyle/ diet modifications.

By signing below I confirm that I have read and understand the risks and benefits of the procedure, and the medical providers have answered all my questions to my satisfaction.
I authorize and consent to the procedure as agreed upon with the medical provider.

Patient Signature:____

Date:___________________