INTRAVENOUS NUTRIENT THERAPY INTAKE FORM

Patient Information

Name: _____Date:_____
Address: _____
City: _____State: _____ ZIP Code:_____
Phone: (H) _____(C)_____ (other)_____
Date of Birth: (MM/DD/YY) _____Age: _____Sex: M / F (Circle One)
Occupation: _____ Email address: _____
In case of emergency, please contact
Name: _____ Phone:_____ Relation: _____
How did you hear about us? ☐Internet ☐Facebook ☐Walk-in ☐Friend: _____
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
□ Cold or flu symptoms
□ Facial wrinkles or fine lines
□ Dull or dry skin
□ Malabsorption issues
□ Intense Workout Regime
□ Other _____

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

□ I want to improve my workouts
□ 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)
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
_____
_____
MEDICAL HISTORY CONTINUED
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
□ 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've had with approximate dates:
_____
Is there anything else you'd like the nurse and physician to know?
_____