

IV THERAPY

MEDICAL HISTORY & INTAKE FORM



Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Phone: _____ Email: _____

Primary Care Provider: _____ City: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

REASON FOR VISIT

Please indicate your primary reason for seeking IV therapy (check all that apply):

- Energy / fatigue
- Brain fog / focus
- Stress / burnout
- Wellness / longevity
- Recovery (illness, travel, lifestyle)
- Athletic performance
- Other: _____

MEDICAL HISTORY

Have you ever been diagnosed with any of the following? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Autoimmune disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Neurological disorder |
| <input type="checkbox"/> Stroke or blood clots | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Arrhythmia or heart rhythm disorder | <input type="checkbox"/> Anxiety or panic disorder |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Depression or other mental health condition |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Chronic fatigue syndrome |
| <input type="checkbox"/> Diabetes or blood sugar disorder | <input type="checkbox"/> Asthma or lung disease |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Cancer (current or past) |
- Other: _____

SURGICAL HISTORY

Please list any past surgeries and approximate dates:

MEDICATIONS & SUPPLEMENTS

Please list all current medications, vitamins, supplements, and injections:

ALLERGIES

Do you have any allergies? (Check all that apply)

- Medications: _____
- Foods: _____
- Latex
- Adhesives
- No known allergies

Have you ever had a reaction to an IV infusion?

- Yes No

If yes, please explain: _____

PREGNANCY & HORMONAL STATUS

- Pregnant Trying to conceive
 Breastfeeding Not applicable
-

LIFESTYLE & WELLNESS

Please answer honestly to ensure safe treatment:

Do you consume alcohol regularly?

- No Yes – How often? _____

Do you use tobacco or nicotine products?

- No Yes

Do you use recreational drugs?

- No Yes

Do you exercise regularly?

- No Yes

Do you have difficulty sitting or reclining for extended periods?

- No Yes – Please explain: _____
-

IV THERAPY SCREENING QUESTIONS

Have you ever experienced any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Fainting with needles | <input type="checkbox"/> Frequent nausea |
| <input type="checkbox"/> Difficulty with IV placement | <input type="checkbox"/> Sensitivity to medications |
| <input type="checkbox"/> Chronic dehydration | <input type="checkbox"/> Anxiety during medical procedures |
-

CONTRAINDICATION SCREENING

Please check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Active cancer treatment | <input type="checkbox"/> Active infection or fever |
| <input type="checkbox"/> Severe kidney disease | <input type="checkbox"/> Known vitamin or mineral toxicity |
| <input type="checkbox"/> Uncontrolled high blood pressure | <input type="checkbox"/> G6PD deficiency |
| <input type="checkbox"/> None of the above | |
-

CURRENT SYMPTOMS

Are you currently experiencing any symptoms today?

- Chest pain
 Shortness of breath
 Dizziness or lightheadedness
 Nausea or vomiting
 Headache
 None

If yes, please explain: _____

PATIENT ACKNOWLEDGEMENT

I certify that the information provided above is accurate and complete to the best of my knowledge. I understand that failure to disclose medical history, medications, or allergies may increase the risk of adverse reactions.

Patient Signature: _____

Date: _____

CLINICAL USE ONLY

Vitals: BP _____ / _____ HR _____ RR _____ Temp _____

IV Therapy Approved: Yes No

Provider Name & Signature: _____ **Date:** _____