I VIE' INTAKE FORM

Name:_____
Date:_____
Address:_____
___
City:_____State:_____Zip
Code:_____
Phone: (H)_____
(C)_____
Occupation:_____ Email
address:_____
In case of Emergency, please
contact:_____ Relationship to
you_____ Phone:_____
Date of Birth:_____(MM/DD/YY) Age_____ M
F

How did you hear about
us?_____
If you were referred, who referred
you?_____

Chief complaints/concerns? Check all that apply.

Fatigue/low energy	Slow Metabolism
Stress	Seasonal allergies
Poor/insufficient diet	Cold/Flu symptoms
Difficulty concentrating	Dull/dry skin
	Facial wrinkles
Headache/Migraines	Fine Lines
Weight gain/loss	Signs of aging

Which following statements best describe why you are here today? Check all that apply.

I want to have more energy and feel better overall I want to nourish my body
I want to prevent becoming sick/ill and/or faster recovery
I want to slow the signs of aging
I want to feel and look younger and more vibrant
I want smoother, brighter, plumper skin
I want to detoxify my body of free radicals and toxins
I want to recover quickly from a hangover

Medical History

Have you recently received any IV infusions? If so, what and when? To include blood or blood products?

Do you have or have had any of the following?

Asthma?
Seasonal allergies
Lung disease, to include COPD, pneumonia, bronchitis? Y/N Sleep apnea? If yes, do you use a CPAP for sleep? Y/N
Episodes of shortness of breath?_____

Bone, skin, or joint problems/disorders? To include autoimmune, acute or chronic pain of any

kind?_____

Heart disease or history of heart issues that require you to see a
cardiologist?_____
__
Pacemaker or
AICD?_____
Arrhythmias or heart palpitations?_____
Fast or slow heart
rate?_____
High or Low blood
pressure?_____
Kidney disease, such as kidney stones, or abnormal kidney lab results?_____
Difficulty with urination?_____
Pain or burning with urination?_____
Bloody or blood-tinged urine?_____
Urinary tract/ kidney or bladder infections?_____

Diabetes? If yes, do you take insulin?_____

Stroke/"mini-strokes"(CVA/TIA)?_____

Any type of Cancer?_____

Blood or bleeding disorders, such as hemophilia, anemia, HIV+, sickle cell, or
Hepatitis?_____
Clotting disorders, such as pulmonary emboli (PE) or blood clots?_____
__ (DVT's) in the arms or legs?_____

Liver disease or any abnormal liver enzyme tests/results?___

Gastrointestinal issues, such as ulcers, heartburn, malabsorption, reflux?_____ Vomiting blood or blood in stool?_____ Nausea, either acute or chronic?_____

<u>For Women ONLY</u>

Are you pregnant or planning to get pregnant? If yes, when is your due date?_____ Last Menstrual Period?_____ Do you currently take Birth Control Pills or any hormone therapy?_____ ___ Are you breastfeeding?_____ Do you have pain, bloating, discomfort, irritability, and/or cramping during your period?_____ Are you menopausal or post-menopausal? If yes, do you take hormones or hormone therapy?_____ Do you have hot flashes or sweating at night?_____

<u>For Men ONLY</u>

Have you had any recent (within one year) kidney, bladder, or prostate infections?_____ Do you have pain or burning with urination?_____ Have issues with entirely emptying your bladder Has the force of your urination decreased?_____ Do you

currently take hormones or hormone therapy, such as Testosterone? If yes, how often?_____

List all surgeries/procedures:

Year	Surgery/Procedure
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Others_____
_____
_____

List **ALL** medications, to include over-the-counter (OTC) supplements, vitamins, Aspirin, Tylenol, Motrin, Advil, Aleve, allergy tablets, weight loss tablets, etc,...

_____

List **ALL** allergies or allergic reactions you have had in the past to any medications; and if so, what kind of reaction?_____
_____
_____
_____

List **ALL** allergies to any food or food products? If so, what kind of reaction have you had?_____
_____
_____
_____

Do you have an allergy specifically to bananas, tapioca, soy, egg or egg products, etc? If yes, what kind of reaction?_____
_____
_____
_____

Do you have any other medical conditions that have not been mentioned above that you would like to inform your doctor or infusion specialist about?_____
_____
_____
_____
_____

Are you currently under the care of a Primary Care Doctor? If yes, whom? And why?

_____

Health Habits

Marital Status: circle one Single Partnered Married Separated Divorced Widowed Undetermined Not certain

Do you use tobacco or are you a smoker? This includes cigars, pipes, vapes, cigarettes, and/or chewing tobacco? If so,
what and how long?_____

Do you use recreational or street drugs? If yes,
what?_____
_____
_____
_____

Do you drink alcohol socially, often, frequently, or simply just too much? Please be honest. I do not judge. If so, what is
your beverage of
preference?_____
_____
_____
_____

How often do you exercise, if at all?

Have you ever been diagnosed with bulemia, anorexia, or any other eating disorders? Take energy or weight loss pills/drinks, to include Xenadrine, Ripped Fuel, etc.?

_____
_____
_____

Tell us what your ultimate goal is for receiving an IV infusion(s). This will help us to improve our services to our clients. Thank you so much!