Concept Chiropractic
+ Regenerative Medicine
Renew Yourself

INTRAVENOUS (IV) INFUSION 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

Occupation:_____ Email address:_____

In case of emergency, please contact: Name: _____ Phone:

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
- ☐ Headaches or migraines
- ☐ Weight gain or difficulty losing weight
- ☐ Slow metabolism
- ☐ Asthma and Allergies
- ☐ Recent surgical procedure
- ☐ Recent illness
- ☐ Cold or flu symptoms
- ☐ Facial wrinkles or fine lines
- ☐ Dull or dry skin
- ☐ Malabsorption issues
- ☐ 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
- ☐ 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)
- ☐ Other _____

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

Name and DOB: _____

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
- ☐ Optic Nerve Atrophy or Leber’s Disease
- ☐ 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?

Name and DOB: _____