# INTRAVENOUS AND INTRAMUSCULAR NUTRITIONAL THERAPY INTAKE FORM

Print Name:_______________________________________________ Date of Birth:__________________

Address________________________________ City____________________ State______ Zip_________

Occupation:____________________________ Email ________________________________________

Mobile No. ____________________ Home No. __________________ Work No. __________________

Emergency Contact Name: ___________________________ Emergency Contact No. _________________

How did you hear about us? ☐ Internet ☐ Social Media ☐ Other: __________________________

May we send you monthly emails regarding our specials and promotions?........................................... ☐ Yes ☐ No

**What are your main concerns?** (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
- ☐ 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 enhance weight loss efforts.
- ☐ I want to recover quickly from my surgery or illness.
- ☐ I want to look and feel younger.
- ☐ I want to recover quickly from a hangover.
- ☐ I want to do everything I can to nourish my body.
- ☐ I want to prevent getting sick.
- ☐ I want to slow the aging process.
- ☐ I want to cleanse my body of toxins.
- ☐ 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? ☐ Yes ☐ No

(If yes, please check all that apply)

- ☐ Hypermagnesemia (high magnesium levels)
- ☐ Hypokalemia (low potassium levels)
- ☐ Hypercalcemia (high calcium 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 in a week? ____________________________________________

☐ How many alcohol drinks do you consume in a week? _______________________________________

☐ Do you use any recreational drugs?................................................................................ ☐ Yes ☐ No

If yes, please specify and detail how often ____________________________________________

**Please list and detail the following:**

| Prescription Medications | Strength | Frequency | Condition Being Treated |
|---|---|---|---|
| ____________________ | ________ | ________ | ______________________________ |
| ____________________ | ________ | ________ | ______________________________ |
| ____________________ | ________ | ________ | ______________________________ |

| Over the Counter Drugs | Strength | Frequency | Condition Being Treated |
|---|---|---|---|
| ____________________ | ________ | ________ | ______________________________ |
| ____________________ | ________ | ________ | ______________________________ |

| Vitamins & Supplements | Strength | Frequency | Condition Being Treated |
|---|---|---|---|
| ____________________ | ________ | ________ | ______________________________ |
| ____________________ | ________ | ________ | ______________________________ |

Do you take Digoxin (Lanoxin) for a heart condition?........................................................................ ☐ Yes ☐ No
Do you take any diuretics or water tablets?.................................................................................... ☐ Yes ☐ No

If yes, please detail

______________________________________________________________________________

Do you take any steroids? (i.e., Prednisone)……………………………………………………..…………………….…… ☐ Yes ☐ No
If yes, please detail

______________________________________________________________________________

Do you have any medication or food allergies?.................................................................................. ☐ Yes ☐ No
If yes, please detail

______________________________________________________________________________

**Do you have or have you experienced any of the following conditions?** (Please check all that apply)

- ☐ Low Or High Blood Pressure
- ☐ Heart Condition(S)
- ☐ Stroke Or "Mini-Stroke"
- ☐ Kidney Problems Or Renal Failure
- ☐ Kidney Stones
- ☐ Asthma
- ☐ Sickle Cell Anemia
- ☐ G6PD Deficiency
- ☐ Sarcoidosis
- ☐ Parathyroid Problems (High Levels)
- ☐ CHF (Congestive Heart Failure)
- ☐ Liver Failure
- ☐ Addison's Disease
- ☐ Thalassemia
- ☐ HIV/AIDS
- ☐ Post Splenectomy
- ☐ Recent Burns
- ☐ Chemotherapy
- ☐ Malnourishment
- ☐ Alcoholism
- ☐ Immunosuppression

**List any other medical conditions you have (not mentioned above:**

______________________________________________________________________________

**List all surgical procedures you've received with approximate dates:**

______________________________________________________________________________

**Is there anything else you'd like the Physician/Practitioner to know?**

______________________________________________________________________________

______________________________________________________________________________

**Printed Name:** ______________________________
**Signature:** ________________________________
**Date:** ____________________________________