The IV Drip Lounge at The Centre for Life Balance

THE CENTRE
FOR LIFE BALANCE

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 _____ (please provide copy if available.)
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)

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□ 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 –Condition being treated

_____
_____
_____

Over the Counter Drugs –Frequency – Condition being treated

_____
_____
_____

Vitamins and Other Supplements – Frequency – Condition being treated

_____
_____
_____

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?

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