



Intake form

Today's Date _____

Name _____

Date of Birth (M/D/Y) _____

Address _____

City _____

Postal Code _____

Phone _____

Email _____

Occupation _____

How did you hear about the IV _____

Emergency Contact _____

Phone _____

Note: By providing your email address you are giving us consent to send you email confirmations for your appointments as well as The IV Wellness Boutique Inc. specials and newsletter.

Primary/Other Health Care Providers

Name _____

Name _____

Profession _____

Profession _____

Phone _____

Phone _____

Health Information

List your health concerns (physical, emotional or psychological) in order of importance to you, and the date your symptoms began:

1. _____ Date _____

2. _____ Date _____

What do you believe is causing your most important health concern?



Allergies and sensitivities

List all allergies to medications, environment and food:

- 1. _____ Reaction _____
- 2. _____ Reaction _____
- 3. _____ Reaction _____
- 4. _____ Reaction _____

Supplements and medications

List all supplements you are currently taking:

Supplement	Daily Dose	How Long	Reason

List all medications you are currently taking:

Medication	Daily Dose	How Long	Reason

Are the medications well tolerated?

- Yes
- No If no, what are the adverse reactions?

Medication _____ Reaction _____



Medical history

List any condition that you have been diagnosed with:

- 1. _____ Date _____
- 2. _____ Date _____
- 3. _____ Date _____
- 4. _____ Date _____

Indicate if you have had any of the following diagnostic tests performed:

	Abnormal Finding		Abnormal Finding
Thyroid Panel <input type="radio"/> Yes / <input type="radio"/> No		Cholesterol <input type="radio"/> Yes / <input type="radio"/> No	
Complete Blood Count <input type="radio"/> Yes / <input type="radio"/> No		EKG <input type="radio"/> Yes / <input type="radio"/> No	
Blood Sugar Test <input type="radio"/> Yes / <input type="radio"/> No		Chest X-Ray <input type="radio"/> Yes / <input type="radio"/> No	
Colonoscopy <input type="radio"/> Yes / <input type="radio"/> No		Mammography <input type="radio"/> Yes / <input type="radio"/> No	

List any past surgeries, hospitalizations, injuries (broken bones, joint sprains, burns, falls, car accidents etc.) or dental work (root canal, mercury or ceramic fillings, implants, caps, dentures etc.):

- 1. _____ Date _____
- 2. _____ Date _____
- 3. _____ Date _____
- 4. _____ Date _____



- 5. _____ Date _____
- 6. _____ Date _____
- 7. _____ Date _____
- 8. _____ Date _____
- 9. _____ Date _____
- 10. _____ Date _____

Women’s health

Check all of the symptoms that apply to you:

- hot flashes vaginal dryness breast tenderness mood swings
- bloating night sweats irritability/impatience headaches
- cramping clots

Men’s health

Check all of the symptoms that apply to you:

- urinary pain urinary urgency urinary hesitancy low libido
- hernia prostate problems discharges/sores sexual difficulties
- testicular mass/pain:

Date of last prostate exam (if applicable): _____



Family History

Indicate whether any family members have had any of the following:

	Relation To You		Relation To You
Alcoholism <input type="radio"/> Yes / <input type="radio"/> No		Diabetes <input type="radio"/> Yes / <input type="radio"/> No	
Allergies <input type="radio"/> Yes / <input type="radio"/> No		Drug Abuse <input type="radio"/> Yes / <input type="radio"/> No	
Alzheimer's Disease <input type="radio"/> Yes / <input type="radio"/> No		Heart Disease <input type="radio"/> Yes / <input type="radio"/> No	
Arthritis <input type="radio"/> Yes / <input type="radio"/> No		High Blood Pressure <input type="radio"/> Yes / <input type="radio"/> No	
Asthma <input type="radio"/> Yes / <input type="radio"/> No		Kidney Disease <input type="radio"/> Yes / <input type="radio"/> No	
Cancer (type) <input type="radio"/> Yes / <input type="radio"/> No		Osteoporosis <input type="radio"/> Yes / <input type="radio"/> No	
Depression <input type="radio"/> Yes / <input type="radio"/> No		Stroke <input type="radio"/> Yes / <input type="radio"/> No	
Other Illnesses <input type="radio"/> Yes / <input type="radio"/> No		Thyroid Condition <input type="radio"/> Yes / <input type="radio"/> No	



System review

Check all symptoms occurring presently or within the past 6 months

General

- recent weight change
- cold intolerance
- health intolerance
- daytime sleepiness
- early waking
- insomnia
- fatigue
- fever

other _____

Head / Eyes / Ears

- headache / migraines
- ear pain
- ear buzzing / ringing
- changes in hearing
- itchy / watery eyes
- changes in vision
- eye pain

other _____

Musculoskeletal

- low back pain
- foot cramps / pain
- joint deformity
- joint pain / stiffness
- muscle pain
- muscle weakness
- muscle spasms/cramps
- tendonitis
- TMJ problems
- tension headaches

other _____

Skin / Nails

- acne (face / torso)
- athlete's foot/jock itch
- dandruff
- bumps on arms
- cellulite
- dark circles under eyes
- lack of sweating
- sweating easily
- eczema / hives / rash
- psoriasis
- oily skin
- itchy skin



- dry skin
- skin darkening
- soft nails
- suspicious moles
- hair loss
- thickening of nails
- changes in pigment
- ridging / spots on nails

other _____

Gastrointestinal

- bloating
- blood or mucus in stool
- flatulence
- haemorrhoids
- food intolerances
- constipation
- pain with stool
- belching
- anal fissures
- jaundice
- diarrhea
- cramps / indigestion
- acid reflux
- undigested food in stool
- nausea

other _____

Respiratory

- breathlessness
- productive cough
- nasal congestion
- sore throat
- exercise intolerance
- hoarseness
- snoring
- dry cough
- seasonal allergies
- wheezing / asthma

other _____

Cardiovascular

- chest pain / angina
- easy bruising
- high blood pressure
- heart palpitations
- varicose veins
- cold hands and feet
- irregular pulse
- swollen ankles / feet

other _____



Urinary

- UTI
- incontinence / dribbling
- discomfort on urination
- frequent urination
- blood in urine

other _____

Lymph / Immune system

- enlarged lymph nodes
- painful / tender nodes
- swelling of extremities
- frequent infections
- slow wound healing

other _____

Mind / Nervous System

- anxiety
- depression
- irritability / impatience
- difficulty concentrating
- poor memory
- fearful / chronic worry
- panic attacks
- numbness / tingling
- speech difficulty
- seizures
- tremor / trembling
- dizziness / vertigo
- light headed / fainting
- loss of balance

other _____

Eating / Appetite

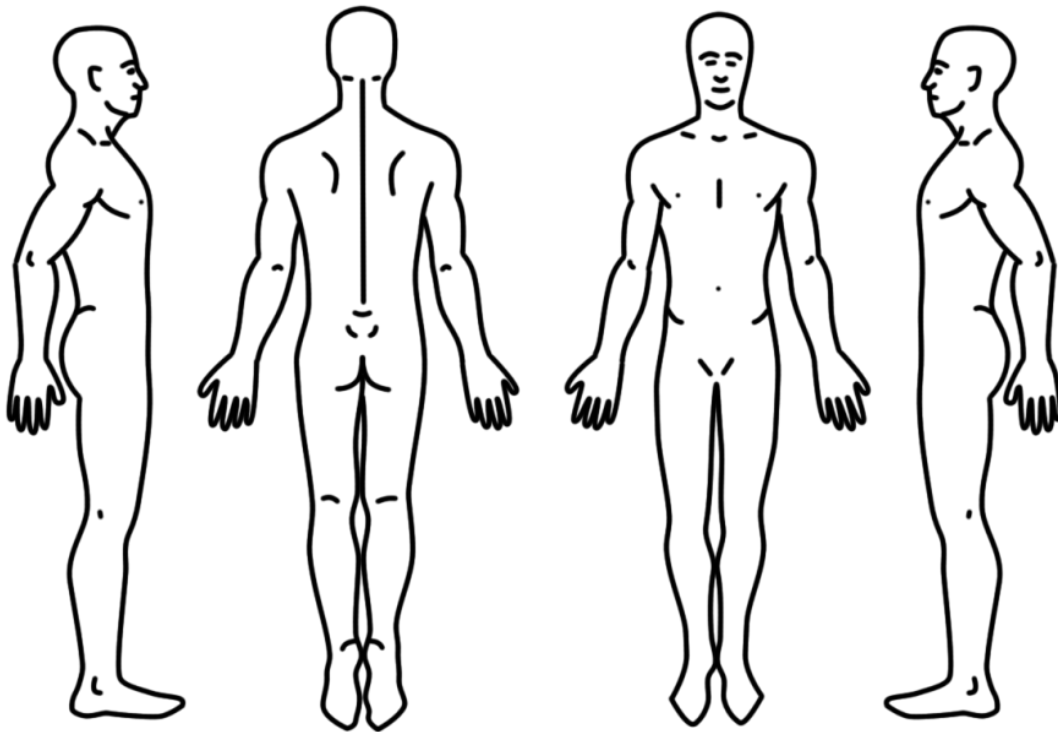
- can't gain weight
- can't lose weight
- frequent dieting
- poor appetite
- always-hungry
- emotional eater
- salt cravings
- carbohydrate cravings
- sugar cravings
- caffeine-dependent
- binge eating
- bulimia / anorexia

other _____

Today's Visit

What are your goals for today's visit?

Indicate on the figure below any areas of concern:



Thank you for visiting the IV!