Intake Form

Name (Print): ______________________ Today's Date: __________

D.O.B.: ______________ Age: ______ Gender: Male ☐ Female ☐

Address: ____

City: ______________ State: ______ Zip Code: __________

Telephone Number: ______________ E-Mail: ______________________

Emergency Contact

Name: ______________________ Telephone Number: ______________

Relation to you: ______________________

Health Concerns/Goals:

- ____
- ____
- ____

Health and Wellness Screening

Do you currently take oral Vitamin C? - - - - - - - - Yes ☐ No ☐

If yes, what dosage and how often? ______________________

Do you take a multivitamin daily? - - - - - - - - - - - - Yes ☐ No ☐

How would you rate your weekly exercise/activity?

Very Active (4+ days per week) ☐ Moderate (2-3 days per week) ☐ Minimal (0-1 day per week) ☐

Describe your exercise habits: ____

How would you rate your diet?

Very conscious ☐ Occasionally conscious ☐ Not concerned ☐

Describe your diet: ____

Have you ever had a complication or reaction from having intravenous nutrition therapy? Yes ☐ No ☐

If yes, describe: ____

Do you have any **Respiratory** complications either past or present? ----------- Yes ☐ No ☐

If yes, describe: ______________________________

Do you have any **Cardiac** complications either past or present? --------------- Yes ☐ No ☐

If yes, describe: ______________________________

Do you have any **Neurological** complications either past or present? ---------- Yes ☐ No ☐

If yes, describe: ______________________________

Do you have any **Kidney or Liver** complications either past or present? --------- Yes ☐ No ☐

If yes, describe: ______________________________

Do you have any **Musculoskeletal** complications either past or present? -------- Yes ☐ No ☐

If yes, describe: ______________________________

Do you have any **Bleeding/Clotting/Lymph** complications either past or present? Yes ☐ No ☐

If yes, describe: ______________________________

Do you have any **Cancer or Autoimmune** complications either past or present? Yes ☐ No ☐

If yes, describe: ______________________________

Are you currently **Pregnant?** ------------------------------ Yes ☐ Unsure ☐ No ☐

If yes, what trimester/how many weeks? ______________________________

Do you take any **Medications?** Either prescription or non prescription. --------- Yes ☐ No ☐

If yes, describe: ______________________________

Do you have any **Allergies?** To medications, foods or anything else? ---------- Yes ☐ No ☐

If yes, describe: ______________________________