Island IV, LLC
VI Medical Foundation Building
9150 Estate Thomas, Suite 203B
St Thomas, USVI 00802-2612

Intake Form

Today's Date:_____

Name: _____Date of Birth: _____

Age: _____ Sex: M / F

Allergies: _____

Address:_____

Phone (cell or home or work):_____ Email address: _____

In case of emergency, please contact:

Name:_____ Phone:_____

How did you hear about us?_____

What are your main complaints? *(Please check all that apply)*

- ☐ Fatigue or low energy ☐ Stress
- ☐ Poor diet due to busy lifestyle ☐ Headaches or migraines
- ☐ Brain fog or trouble concentrating ☐ Low mood or depression
- ☐ Weight gain or difficulty losing weight ☐ Slow metabolism
- ☐ Asthma and Allergies ☐ Recent surgical procedure
- ☐ Recent illness ☐ Cold or flu symptoms
- ☐ Dull or dry skin ☐ Malabsorption issues
- ☐ Cancer
- ☐ 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 _____

(Females only) Are you pregnant or breastfeeding? Yes / No

Date of last labs 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) ☐ B12 deficiency ☐ Vitamin D deficiency
- ☐ Antioxidant deficiency such as Glutathione ☐ Hypercalcemia (High calcium levels)
- ☐ Hypokalemia (Low potassium levels) ☐ Hemochromatosis (High iron levels)
- ☐ Other _____

Are you a smoker? Yes / No If Yes, how much do you smoke and for how long?_____

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? _____

Prescription Medications – Strength – Frequency

_____

_____

Over the Counter Drugs – Strength – Frequency

_____

_____

Vitamins and Other Supplements – Strength – Frequency

_____

_____

Do you take Digoxin (Lanoxin) or Coumadin (Warfarin) for a heart problem? Yes / No

Do you take any diuretics or water pills? Yes / No If Yes: _____

Do you take any steroids, i.e. Prednisone? Yes / No If Yes: _____

Do you have any medication or food allergies? Yes / No If Yes: _____

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

☐ Blood pressure problems (High or low) ☐ Heart Problems, if so, _____

☐ Stroke or "mini-stroke" ☐ Kidney Problems ☐ Diabetes (1 or 2?) ☐ Kidney Stones

☐ Autoimmune Condition(s) ☐ Cancer ☐ Sickle Cell Anemia ☐ G6PD Deficiency ☐ Parathyroid problems

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

_____

List of all surgical procedures you've had with approximate dates:

_____

FINANCIAL

I understand that insurance **WILL NOT** be accepted for nutrient infusions. Payment can be made in the form of Cash, Check, Money Order or PayPal, Venmo and Cash App. I will be given a receipt after each payment. I have been given the opportunity to ask questions regarding this statement.

Signature of Responsible Party:_____

Printed Name of Responsible Party:_____

Date:_____

You will be evaluated by a trained and licensed provider. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good relationship between us. Please read through this information, asking questions as needed.

1.INITIAL INTERVIEW: Your first history and physical is considered an evaluation interview and exam. At the time of this appointment, the following decisions will be made with you:

a) If Nutrient infusions is an appropriate treatment option
b) Frequency of infusion sessions
c) Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment varies in length depending on the nutrient and dose. At the end of each appointment you can make arrangements for your next appointment or you may also book all your prescribed appointments at once.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list.

4. PAYMENTS: We would greatly appreciate payment in full for each visit prior to the start of your appointment. WE WILL ACCEPT CASH, CHECK, MONEY ORDERS, Venmo (@islandivhydration), CASH APP($IslandIV) and PAYPAL (@islandivhydration). PLEASE MAKE CHECKS OUT TO “ISLAND IV”.

5. CONFIDENTIALITY: All information regarding the specific nature of your treatment is maintained at At our office and is considered confidential within the office unless specified by you in writing. We follow HIPAA and maintain confidentiality.

I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions. Initial_____

I consent to the exchange of treatment information between Island IV LLC and my primary care or mental health provider. Initial_____

Patient(s):_____

Physician’s Name/Office & Phone Number:_____

Sign & Date:_____

For Clinic Use Only

Physical Exam (Focused, Brief)

BP_____ HR_____ SpO2_____ RR_____ Temp_____ WT _____

Refer to Order Set

Practitioner Name:

Date:

Practitioner Signature: