**HEALTH HISTORY QUESTIONNAIRE**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number for referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Military service? Yes No Branch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Period of Service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of smoking or tobacco use? Yes No

Do you drink alcohol? Yes No How many drinks per week? \_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS**

Please list the dose and frequency of any medications you are currently taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**

List medication allergies, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to latex? Yes No I don’t know

Are you allergic to iodine or shellfish? Yes No I don’t know

**SURGICAL HISTORY** *Please list any surgeries you have had:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Do you have any of the following medical problems? Circle all that apply:

Heart Disease: Endocrine:

Heart Attack Diabetes

Congestive Heart Failure Thyroid Problems

Arrythmia (irregular beats) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure

Other Heart \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lung Disease: Other:

Asthma Stroke

COPD GERD/Acid Reflux

Other Lung\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Migraines

Arthritis

Kidney or Liver Disease: Stomach ulcers

Renal Failure G6PD Deficiency

Kidney Stones Depression

HIV / Hepatitis B / Hepatitis C

List other medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other drug use:**

Please list all drugs like steroids, meth, spice, etc you use: (we are not here to judge only to make sure you are safe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT**

I (PRINT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_ give consent to Rejuvenate IV Hydration and Wellness Center to perform intravenous vitamin, mineral and medical therapy. I understand that intravenous nutrient therapy is not standard, widely approved or accepted for the purpose(s) of treatment of prevention of disease and the view that it is of benefit in the treatment of such disorders is accepted by a minority of the medical community and is considered “experimental” by most physicians. I am advised that other treatment approaches have been used in these conditions, including but not limited to prescription medications, over-the-counter drugs and nutritional supplements and these alternatives have been explained to my full satisfaction.   
  
I understand that the benefits of intravenous nutrient therapy are much greater if I follow a healthy lifestyle (non-smoking, weight control, proper exercise, proper diet and nutritional supplementation. I understand that it is my option to stop at any time with this treatment without incurring any further expense after I have directed that such treatment be stopped. As with any other medical procedure, a small percentage of clients do not respond or may have adverse reactions to this therapy.   
  
I have been informed of possible risks and side effects including but not limited to discomfort at the injection site, thrombophlebitis, fatigue, allergic reaction, congestive heart failure, lowering of blood sugar levels, fever, and chills and generalized complaints. I understand that this therapy should not be used if I am pregnant unless I have discussed and have written permission from my maternal health provider. I understand the nature of the proposed therapy and the risks and dangers have been explained to me to my full satisfaction. 

While I understand that there have been no warranties or guarantees of successful treatment made to me, I desire to undergo this treatment after having considered the information contained in this document, the information provided to me through conversations and materials that may be provided to me by the office to educate me about the treatment. I acknowledge that I have had the opportunity to ask questions and with respect to my proposed therapy and the treatments to be utilized and all my questions have been answered to my full satisfaction.   
  
My signature on this agreement will constitute a full and final release of any legal responsibility resulting from the administration of intravenous nutrient therapy in my case and/or any other medical treatments that may be necessary as a result thereof. This consent is for all treatments now and in the future provided to you by the staff at Rejuvenate.  
Bottom of Form

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Witness :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Top of Form

Rev 2/2020

**HIPPA**

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. A Notice of Privacy Practices should be available to you in the office. The notice provides information about how we may use and disclose protected health information about you in order to carry out treatment, payment, and healthcare operations, and for other purposes permitted or required by law. The notice also contains information about your rights under the law. Additional information is available from the U.S. Department of Health and Human Services. By signing below you understand and agree to the terms of our notice of privacy practices which include:

* Protected health information may be disclosed or used for treatment, payment, or health care operations.
* Authorization is required for certain disclosures of your Protected Health Information.
* You have the right to opt out of fundraising communications.
* You have the right to restrict disclosures of your Protected Health Information under certain circumstances.
* You have the right to be notified of a breach of unsecured Protected Health Information. By signing below you understand and agree that:
* The practice has a Notice of Privacy Practices that you have had the opportunity to review.
* The practice reserves the right to change the Notice of Privacy Practices and if we change our notice you may obtain a revised copy by contacting our office
* You may revoke this consent in writing at any time and all future disclosures will cease
* The practice may condition treatment upon execution of this consent.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_