Cultivating Resilience, LLC  **IV Hydration Therapy**

INTAKE QUESTIONNAIRE

Date: _____

Name: _____ DOB: _____ Age: _____

Address:

_____

Phone: _____ Email: _____

Reason for Visit: _____

Emergency Contact: _____

Please briefly describe why you are seeking IV infusion or injection therapy. For example: Are you looking to improve your energy, skin/hair/nail quality, recovery times, immune system, or hydration status? Are you seeking treatment for a hangover or seeking to feel or look better?

_____

_____

_____

Allergies (Medications, foods, *etc.*):

_____

_____

_____

Current Medications (Please include over-the-counter medications and supplements):

_____

_____

_____

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Please check any conditions that apply to you:

CARDIOVASCULAR AND RESPIRATORY

- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Valve Disorder
- ☐ Abnormal Rhythm
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Cardiac Surgery or Stents
- ☐ Congestive Heart Failure
- ☐ Peripheral Artery Disease
- ☐ Thrombosis or DVT
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Pulmonary Hypertension
- ☐ Lung Cancer
- ☐ Aneurysm
- ☐ Other Cardiac Disorder: _____
- ☐ Other Lung Disorder: _____

GASTROINTESTINAL AND URINARY

- ☐ Acid Reflux
- ☐ Bladder Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Hepatitis A, B, C
- ☐ Other: _____

METABOLIC/ENDOCRINE/AUTOIMMUNE

- ☐ Hyper-/Hypo-Thyroid
- ☐ Diabetes Type I Type II
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ History of DKA
- ☐ Other: _____

NEUROLOGIC

- ☐ Stroke/TIA
- ☐ Multiple Sclerosis
- ☐ Alzheimer's Disease
- ☐ Seizures (date of last seizure): _____
- ☐ Parkinson's Disease

HEMATOLOGY

- ☐ Anemia (Iron Deficiency, Pernicious, Aplastic, Hemolytic, Sickle Cell)
- ☐ MTHFR
- ☐ G6PD Deficiency

MUSCULOSKELETAL

- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Degenerative Joint Disease
- ☐ Degenerative Disk Disease
- ☐ Other: _____

PSYCHOLOGICAL

- ☐ Depression
- ☐ Anxiety or Panic Attacks
- ☐ Suicidal Thoughts

PAIN

- ☐ CRPS
- ☐ Fibromyalgia

CANCER

- ☐ Location of cancer _____
- ☐ Chemotherapy
- ☐ Radiation

WOMEN (non-menopausal)

Last Menstrual Period: _____ Any chance that you are pregnant? _____

Are you currently breastfeeding? _____

Do you drink alcohol or abuse any types of drugs? If so, please explain:

_____

_____

_____

Have you ever had an electrolyte or fluid imbalance in the past? Such as low potassium, high sodium, etc.?

_____

_____

_____

Would you like to tell us anything else that you feel is important?

_____

_____

_____

I attest that the information I have provided is true and accurate to the best of my knowledge:

_____

Signature Date

_____

Print Name