Integrative Rheumatology

IV Hydration Therapy Intake Form

Patient Information

Name _____ DOB _____ Age _____

_____

Street Address *City* *State* *Zip*

In case of emergency, please contact: _____

Name *Phone #*

How did you hear about us? ❑ Internet ❑ Facebook/Instagram ❑ Walk-in ❑ Friend: _____

Have you had IV Hydration before? ❑ Yes ❑ No

If YES, did you experience any complications or adverse reactions? ❑ Yes ❑ No

Describe your reaction _____

What statements best describe your goals for 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 prevent getting sick.
- ❑ I want to look and feel younger.
- ❑ I want to recover quickly from my surgery or illness.
- ❑ I want to cleanse my body of toxins.
- ❑ Other _____

I am interested in exploring these enhancements to help manage my health.
(Please check all that apply)

- ❑ Rheumatologic consultation
- ❑ Nutritional counseling
- ❑ Weight loss program
- ❑ Natural supplements
- ❑ Essential Oils
- ❑ Massage
- ❑ Other _____

Medical History

Primary Care Physician _____

Provider Name *Practice Name/ Office Phone*

Last Office Visit (Mo/Yr) _____

Do you experience any of the following symptoms? *(Please check all that apply)*

- ❑ Joint pain or stiffness
- ❑ Joint swelling, redness, or warmth
- ❑ Unexplained muscle pain or weakness
- ❑ Fatigue or low energy
- ❑ Frequent dry eyes or dry mouth
- ❑ Recurrent rash

If so, please provide additional details _____

_____

Do you use any of the following substances? *(Please check all that apply)*

- ❑ Smoking If yes, how much? _____
- ❑ Alcohol If yes, how much? _____
- ❑ Recreational drugs If yes, which ones and how often? _____

Patient Name _____ DOB _____

PAST MEDICAL HISTORY

Do you have any of the following conditions? *(Please check all that apply)*	**Have you ever been told that you have an electrolyte imbalance or other abnormal labs?** *(Please check all that apply)*
❑ Pregnancy or breastfeeding ❑ High or Low blood pressure ❑ Heart disease ❑ Arrhythmias ❑ Diabetes ❑ Stroke or "mini-stroke" ❑ Kidney disease ❑ Kidney stones ❑ Dialysis ❑ Asthma ❑ Sickle Cell Anemia	❑ Hypermagnesemia (high magnesium levels) ❑ Hypercalcemia (high calcium levels) ❑ Hypokalemia (low potassium levels) ❑ Hyperkalemia (high potassium levels) ❑ Hemochromatosis (high iron levels)

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

_____

_____

_____

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

_____

_____

MEDICATIONS

Please list prescription medications you are taking. Include dose, frequency, condition being treated.

_____

_____

_____

Please list over the counter medications, vitamins and other supplements you take. Include dose, frequency, condition being treated.

_____

_____

_____

Do you take digoxin (Lanoxin) for heart problems? ❑ Yes ❑ No

Do you take any diuretics or water pills? ❑ Yes ❑ No

Do you take any steroids (i.e. prednisone)? ❑ Yes ❑ No

ALLERGIES to medications and food _____

_____

_____

~~*~*~*~*

The above information is complete and accurate to the best of my knowledge. _____

Signature *Date*

Office Use Only