4408 NW 36 AVE - Gainesville, FL 32606
Phone: (352) 448-6062 | www.flmindhealth.com

IV INTRAVENOUS THERAPY INTAKE FORM

Patient Information:

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Postal Code: _____
Phone: (H) _____(Cell) _____
Date of Birth: _____(YYYY/MM/DD) Age: ____ Sex: M / F / □ _____
Occupation: _____ Email: _____
By providing my email, I agree to receiving clinic email reminders, health updates, promotions, etc.
In case of emergency, whom should we contact: _____
How did you find out about our services? _____

Why would you like to receive IV Therapy?

_____
_____

Have you received IV Therapy before? What was your experience like?

_____
_____

Please check if you have any of the following conditions that IV Therapy can help with:

□ Fatigue	□ Low Depressed Mood	□ Anemia
□ Weight Issues	□ Irritability/Moodiness	□ Trying to get Pregnant/Fertility Prep
□ Stress	□ PMS	□ Allergies
□ Sleep Disorders	□ Asthma	□ IBS/Inflammatory Bowels
□ Low Immunity	□ Digestive Issues	□ Numbness/Tingling of body
□ Migraines	□ Muscle Spasms	□ Aging

Please list all allergies (known and suspected):

_____
_____

Please list all current and past medical conditions, diagnosis, hospitalizations, surgeries:

_____
_____

Please list all prescription drugs and supplements you are currently taking and doses:

_____
_____
_____

Date of last Physical Exam/Blood Test:_____

Any abnormal results from blood test?_____

Do you have any medical devices implanted in your body? Pins, Plates, Pacemakers?

_____

Please check if you have any of the diagnoses below:

□ High Blood Pressure	□ Arrhythmia	□ Abnormal EKG	□ CHF
□ Low Blood Pressure	□ Angina	□ MI / Heart Attack	□ Diabetes
□ Bleeding Disorder	□ Ankle Swelling	□ Kidney Disease	□ Asthma
□ G6PD Deficiency	□ Anxiety	□ Congestive Heart Failure	□ Edema
□ Sudden Weight Loss	□ Cancer		

Over the last 2 weeks, how often have you been bothered by the following problems?
(Use "X" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

Additional notes:

Signature: _____ Date: _____
(YYYY - MM - DD)