the IV health centre

Intake form

Today's Date _____

Name _____ Date of Birth (M/D/Y)_____

Address _____City_____

Postal Code _____ Phone _____

Email _____ Occupation _____

How did you hear about the IV _____

Emergency Contact _____ Phone _____

Note: By providing your email address you are giving us consent to send you email confirmations for your appointments as well as The IV Wellness Boutique Inc. specials and newsletter.

Primary/Other Health Care Providers

Name _____ Name _____

Profession _____ Profession _____

Phone _____ Phone _____

Health Information

List your health concerns (physical, emotional or psychological) in order of importance to you, and the date your symptoms began:

1. _____ Date _____

2. _____ Date _____

What do you believe is causing your most important health concern?

_____

_____

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Allergies and sensitivities

List all allergies to medications, environment and food:

1. _____ Reaction _____

2. _____ Reaction _____

3. _____ Reaction _____

4. _____ Reaction _____

Supplements and medications

List all supplements you are currently taking:

Supplement	Daily Dose	How Long	Reason

List all medications you are currently taking:

Medication	Daily Dose	How Long	Reason

Are the medications well tolerated?

○ Yes ○ No If no, what are the adverse reactions?

Medication _____ Reaction _____

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Medical history

List any condition that you have been diagnosed with:

1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

4. _____ Date _____

Indicate if you have had any of the following diagnostic tests performed:

	Abnormal Finding		Abnormal Finding
Thyroid Panel ○ Yes / ○ No		Cholesterol ○ Yes / ○ No	
Complete Blood Count ○ Yes / ○ No		EKG ○ Yes / ○ No	
Blood Sugar Test ○ Yes / ○ No		Chest X-Ray ○ Yes / ○ No	
Colonoscopy ○ Yes / ○ No		Mammography ○ Yes / ○ No	

List any past surgeries, hospitalizations, injuries (broken bones, joint sprains, burns, falls, car accidents etc.) or dental work (root canal, mercury or ceramic fillings, implants, caps, dentures etc.):

1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

4. _____ Date _____

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5. _____ Date _____

6. _____ Date _____

7. _____ Date _____

8. _____ Date _____

9. _____ Date _____

10. _____ Date _____

Women's health

Check all of the symptoms that apply to you:

○ hot flashes ○ vaginal dryness ○ breast tenderness ○ mood swings

○ bloating ○ night sweats ○ irritability/impatience ○ headaches

○ cramping ○ clots

Men's health

Check all of the symptoms that apply to you:

○ urinary pain ○ urinary urgency ○ urinary hesitancy ○ low libido

○ hernia ○ prostate problems ○ discharges/sores ○ sexual difficulties

○ testicular mass/pain:

Date of last prostate exam (if applicable): _____

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Family History

Indicate whether any family members have had any of the following:

	Relation To You		Relation To You
Alcoholism ○ Yes / ○ No		Diabetes ○ Yes / ○ No	
Allergies ○ Yes / ○ No		Drug Abuse ○ Yes / ○ No	
Alzheimer's Disease ○ Yes / ○ No		Heart Disease ○ Yes / ○ No	
Arthritis ○ Yes / ○ No		High Blood Pressure ○ Yes / ○ No	
Asthma ○ Yes / ○ No		Kidney Disease ○ Yes / ○ No	
Cancer (type) ○ Yes / ○ No		Osteoporosis ○ Yes / ○ No	
Depression ○ Yes / ○ No		Stroke ○ Yes / ○ No	
Other Illnesses ○ Yes / ○ No		Thyroid Condition ○ Yes / ○ No	

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System review

Check all symptoms occurring presently or within the past 6 months

General

○ recent weight change ○ cold intolerance ○ health intolerance

○ daytime sleepiness ○ early waking ○ insomnia

○ fatigue ○ fever

other _____

Head / Eyes / Ears

○ headache / migraines ○ ear pain ○ ear buzzing / ringing

○ changes in hearing ○ itchy / watery eyes ○ changes in vision

○ eye pain

other _____

Musculoskeletal

○ low back pain ○ foot cramps / pain ○ joint deformity

○ joint pain / stiffness ○ muscle pain ○ muscle weakness

○ muscle spasms/cramps ○ tendonitis ○ TMJ problems

○ tension headaches

other _____

Skin / Nails

○ acne (face / torso) ○ athlete's foot/jock itch ○ dandruff

○ bumps on arms ○ cellulite ○ dark circles under eyes

○ lack of sweating ○ sweating easily ○ eczema / hives / rash

○ psoriasis ○ oily skin ○ itchy skin

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○ dry skin ○ suspicious moles ○ changes in pigment

○ skin darkening ○ hair loss ○ ridging / spots on nails

○ soft nails ○ thickening of nails

other _____

Gastrointestinal

○ bloating ○ constipation ○ diarrhea

○ blood or mucus in stool ○ pain with stool ○ cramps / indigestion

○ flatulence ○ belching ○ acid reflux

○ haemorrhoids ○ anal fissures ○ undigested food in stool

○ food intolerances ○ jaundice ○ nausea

other _____

Respiratory

○ breathlessness ○ exercise intolerance ○ dry cough

○ productive cough ○ hoarseness ○ seasonal allergies

○ nasal congestion ○ snoring ○ wheezing / asthma

○ sore throat

other _____

Cardiovascular

○ chest pain / angina ○ heart palpitations ○ irregular pulse

○ easy bruising ○ varicose veins ○ swollen ankles / feet

○ high blood pressure ○ cold hands and feet

other _____

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Urinary

○ UTI ○ incontinence / dribbling ○ discomfort on urination

○ frequent urination ○ blood in urine

other _____

Lymph / Immune system

○ enlarged lymph nodes ○ painful / tender nodes ○ swelling of extremities

○ frequent infections ○ slow wound healing

other _____

Mind / Nervous System

○ anxiety ○ depression ○ irritability / impatience

○ difficulty concentrating ○ poor memory ○ fearful / chronic worry

○ panic attacks ○ numbness / tingling ○ speech difficulty

○ seizures ○ tremor / trembling ○ dizziness / vertigo

○ light headed / fainting ○ loss of balance

other _____

Eating / Appetite

○ can't gain weight ○ can't lose weight ○ frequent dieting

○ poor appetite ○ always-hungry ○ emotional eater

○ salt cravings ○ carbohydrate cravings ○ sugar cravings

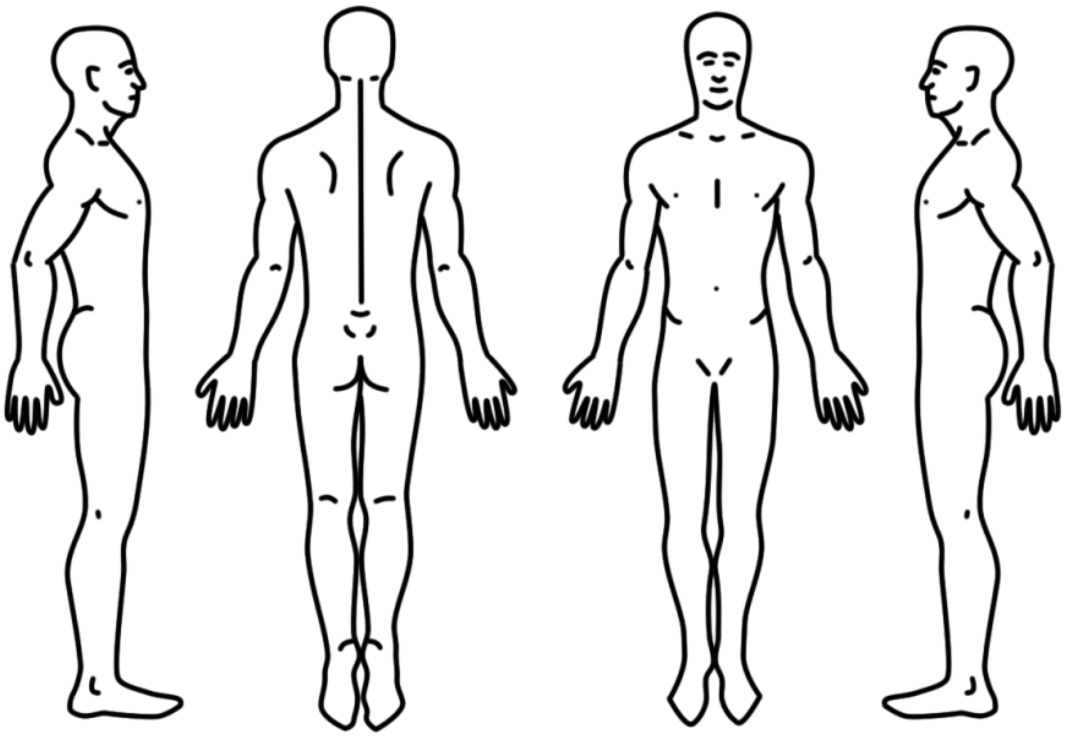
○ caffeine-dependent ○ binge eating ○ bulimia / anorexia

○ other _____

Today's Visit

What are your goals for today's visit?

Indicate on the figure below any areas of concern:



Thank you for visiting the IV!