the IV health centre

Intake form

Today's Date _____

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

Address _____ City_____

Postal Code _____ Phone _____

Email _____ Occupation _____

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.

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?

_____

_____

What level of stress do you feel you are experiencing at this time? Please quantify on a scale of 1 (low) to 10 (high):

What are the major causes or factors of your stress? *Rate all that apply on a scale of 1 (low) to 10 (high):*

Financial: Career: Family: Health: Family: Spiritual: Unfulfilled Expectations:

How does your stress manifest itself?

_____

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Do you use any coping mechanisms?

_____

_____

What do you do for exercise? (Indicate type, frequency, time of day and duration)

_____

_____

On a scale of 1-10, how would you rate your energy levels?

On average, how many hours of sleep do you get?

Allergies and sensitivities

List all allergies to medications, environment and food:

1. _____ Reaction _____

2. _____ Reaction _____

3. _____ 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

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Medical history

List any condition that you have been diagnosed with:

1. _____ Date _____

2. _____ Date _____

Indicate if you have had any of the following diagnostic tests performed (thyroid panel, blood sugar, bone density) What were the results?

_____

_____

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 _____

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

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○ testicular mass/pain:

Date of last prostate exam (if applicable): _____

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 (indicate type) ○ Yes / ○ No		Osteoporosis ○ Yes / ○ No	
Depression ○ Yes / ○ No		Stroke ○ Yes / ○ No	
Other Illnesses ○ Yes / ○ No		Thyroid Condition ○ Yes / ○ No	

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Symptom 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

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

○ psoriasis ○ oily skin ○ itchy skin

○ 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 _____

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 _____

Please indicate how many cups of the following you drink per day:

Tap water:
Coffee:
Tea:
Soft drinks:
Fruit juices:
Dairy Milk:
Alcoholic Beverages:

Are you a meat eater?

How often do you eat meat?

How often do you consume dairy products?

What are your favourite foods and how often are they consumed?

_____

_____

Which food(s) do you crave, and how often do you eat them?

_____

_____

Do you avoid certain foods? If so, why?

_____

_____

Do you experience any symptoms if meals are missed?

_____

_____

Do you experience any symptoms after meals?

_____

_____

Please provide examples of typical meals:

Breakfast:

Lunch:

Dinner:

Snacks:

What would you like to gain from today's visit?

_____

_____

How did you hear about the IV? Did someone refer you?

_____

Would you like to receive our newsletter for the latest news and gift offerings?

○ Yes / ○ No