the IV health centre

IV Therapy Intake Form

Today's Date _____

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

Address _____ City _____

Postal Code _____ Phone _____

Email _____ Occupation _____

Note: By providing your email address you are giving the IV consent to send you email confirmations of your appointments as well as the IV health centre's features and newsletter.

How did you hear about the IV? ○ IV Website ○ Instagram ○ Facebook ○ Radio
○ Google ○ Family / Friend ○ Special Event ○ Other: _____

How did you hear about your Practitioner? ○ Website ○ Instagram ○ Facebook
○ Family / Friend ○ Referral - If so, who referred you: _____

Health Care Provider: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Other Health Care Practitioners:

Name: _____ Phone: _____

Name: _____ Phone: _____

Health Information

List your health concerns in order of importance to you, and the date your symptoms began:

1. _____ 3. _____

2. _____ 4. _____

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

_____

_____

_____