

# IV Nutrition Intake Questionnaire

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address:  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Reason for visit:  
\_\_\_\_\_

Emergency Contact:  
\_\_\_\_\_

Please briefly describe why you are seeking IV infusion or injection therapy? For example: Are you looking to improve your energy, skin/hair/nail quality, recovery times, immune system, or hydration status? Are you seeking treatment for a hangover or looking to feel and look better?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies (Medications, foods, etc.):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications: (Please include OTC & supplements)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## IV Nutrition Intake Questionnaire

Please check any conditions that apply to you:

### CARDIOVASCULAR AND RESPIRATORY

- |  |   |
|--|---|
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Asthma                       |
| <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> COPD                         |
| <input type="checkbox"/> Valve Disorder            | <input type="checkbox"/> Sleep Apnea                  |
| <input type="checkbox"/> Abnormal Rhythm           | <input type="checkbox"/> Shortness of Breath          |
| <input type="checkbox"/> Chest Pain                | <input type="checkbox"/> Pulmonary Hypertension       |
| <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> Lung Cancer                  |
| <input type="checkbox"/> Cardiac Surgery or Stents | <input type="checkbox"/> Other Lung Disorder _____    |
| <input type="checkbox"/> Congestive Heart Failure  | <input type="checkbox"/> Other Cardiac Disorder _____ |
| <input type="checkbox"/> Peripheral Artery Disease |   |
| <input type="checkbox"/> Thrombosis or DVT         |   |
| <input type="checkbox"/> Aneurysm                  |   |

### GASTROINTESTINAL AND URINARY

- |  |  |
|--|--|
| <input type="checkbox"/> Acid Reflux     | <input type="checkbox"/> Liver Disease     |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Hepatitis A, B, C |
| <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Other _____       |

### METABOLIC/ENDOCRINE/AUTOIMMUNE

- |  |   |
|--|---|
| <input type="checkbox"/> Hyper/Hypo Thyroid      | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes Type I Type II | <input type="checkbox"/> Hx of DKA            |
| <input type="checkbox"/> Lupus                   | <input type="checkbox"/> Other _____          |

### NEUROLOGIC

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Stroke/TIA                            |                                      |
| <input type="checkbox"/> Multiple Sclerosis                    | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Seizures – date of last seizure _____ | <input type="checkbox"/> Alzheimer's |

### HEMATOLOGY

- |   |
|---|
| <input type="checkbox"/> Anemia (Iron Deficiency, Pernicious, Aplastic, Hemolytic, Sickle Cell) |
| <input type="checkbox"/> MTHFR  |
| <input type="checkbox"/> G6PD Deficiency  |

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### MUSCULOSKELETAL

- Back Pain     Degenerative Joint Disease  
 Carpal Tunnel Syndrome     Degenerative Disk Disease  
 Fibromyalgia     Other \_\_\_\_\_

### PSYCHOLOGICAL

- Depression  
 Anxiety or Panic Attacks  
 Suicidal Ideations

### CANCER

- Location of cancer \_\_\_\_\_  
 Chemotherapy  
 Radiation

### WOMEN (non-menopausal)

Last Menstrual Period \_\_\_\_\_ Any chance that you are pregnant? \_\_\_\_\_  
Are you currently breastfeeding? \_\_\_\_\_

### PAIN

- CRPS  
 Fibromyalgia

Do you drink alcohol or abuse any types of drugs? If so, please explain:

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Have you ever had an electrolyte or fluid imbalance in the past? Such as low potassium, high sodium, etc.?

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Would you like to tell us anything else that you feel like is important?

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I attest that the information I have provided is true and accurate to the best of my knowledge:

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Signature

Date

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Print name