INFUSION WELLNESS

INTAKE QUESTIONNAIRE

1260 Lincoln Avenue, Fennimore, WI 53809 | 608-822-0305

Date: ____/____/____

Name: _____ DOB: ____/____/____ Age: _____

Address: _____

Phone: ____-____-_____ Email: _____

Emergency Contact: _____ Phone: ____-____-_____

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): _____

_____

_____

Please check any conditions that apply to you:

CARDIOVASCULAR AND RESPIRATORY

- ☐ Abnormal Rhythm
- ☐ Cardiac Surgery or Stents
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Valve Disorder
- ☐ Aneurysm
- ☐ Peripheral Artery Disease
- ☐ Thrombosis or DVT
- ☐ Other Cardiac Disorder: _____
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ COPD
- ☐ Lung Cancer
- ☐ Pulmonary Hypertension
- ☐ Shortness of Breath
- ☐ Other Lung Disorder: _____

GASTROINTESTINAL AND URINARY

- ☐ Acid Reflux
- ☐ Bladder Disease
- ☐ Hepatitis A, B, C
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Other _____

METABOLIC/ENDOCRINE/AUTOIMMUNE

- ☐ Diabetes Type I Type II
- ☐ Hx of DKA
- ☐ Hyper/Hypo Thyroid
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Other _____

NEUROLOGIC

- ☐ Alzheimer's
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Stroke/TIA
- ☐ Seizures – date of last seizure ___/___/____

HEMATOLOGY

- ☐ Anemia (Iron Deficiency, Pernicious, Aplastic, Hemolytic, Sickle Cell)
- ☐ G6PD Deficiency
- ☐ MTHFR

MUSCULOSKELETAL

- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Degenerative Disk Disease
- ☐ Degenerative Joint Disease
- ☐ Fibromyalgia
- ☐ Other_____

PSYCHOLOGICAL

- ☐ Anxiety or Panic Attacks
- ☐ Depression
- ☐ Suicidal Ideations

CANCER

- ☐ Chemotherapy
- ☐ Radiation
- ☐ Location of cancer _____

PAIN

- ☐ CRPS
- ☐ Fibromyalgia

WOMEN (non-menopausal)

Last Menstrual Period: ____/____/____ Any chance that you are pregnant? _____

Are you currently breastfeeding? _____

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

_____

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

_____

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

_____

_____

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

_____ _____ ____/____/____

Print name Signature Date