IV Nutrient Therapy Intake Form

Referring Doctor ____

Patient ____ Date ____________

Date of birth __________________________ Age ______________ Sex ____________

Reason for referral including ICD-9 code ______________________________________

Allergies   Asthma   Autoimmune dz.   Cachexia   Cardiovascular dz.   Cancer Support

Depression   Drug Withdrawal   Fatigue   Fibromyalgia   Hepatitis C   HIV

Hyperthyroidism   Immune Support   Malnutrition/Malabsorption   Migraines   Pain

Neurological Disorders   Respiratory Infection   Tissue & Wound Healing   Urticaria

Viral Infection   Other ____

Comments on current health concerns ____________________________________

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Date of last chemistry screen ____________ Abnormal results ________________

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Past Medical History – Has the patient ever been diagnosed with:

Hypertension   Angina   Ankle swelling   Arrhythmia   CHF   MI   DM

Abnormal EKG   Kidney dz.   Gen. Edema   Bleeding disorder   Asthma   Cancer

Pulmonary edema   Sudden weight loss   Anxiety/panic attack   G6PD Deficiency

Is patient pregnant? ___________   Known Allergens ______________________

Allergy to Latex ____________   Shellfish ________________   Iodine ______________

Pertinent details of conditions checked above __________________________

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Referring Doctor Signature ______________________________ Date ______________

Address ____

Phone ____ Fax ____________________