IV Therapies Intake and Consent Form

Please help me provide you with a complete and thorough evaluation by completing this questionnaire fully. This form contains your Intake Form, IV Consent Form, Pre-IV Instructions and Ozone Consent Form.

Your information is kept private and confidential as per the Ontario Privacy Act

Name: _____ Birthday: _____/_____/_____ Age: ___
(Printed Full Name) mm dd yyyy

(Optional) Preferred Pronoun _____

Address:_____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone #:_____

Cellular Phone #:_____ Email: _____

How did you find out about us? Personal Referral Professional Referral Google/Website Walking By Other _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

To better understand your life's context (pressures, supports, stresses, exposures):

Marital Status: □ Single □ Common-Law □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____ Occupation: _____

Your Health Care Team

Medical Doctor: _____ Phone #: _____

Specialist/Other: _____ Phone #: _____

Date of last physical exam (approx.): _____

Health Concerns

1. Main reasons for seeking IV care.

_____

_____

_____

_____

2. How are you affected by this?

_____

_____

_____

3. Have you Had IV Therapies before? Y or N and if so what kind?

_____

_____

- Were you referred by another care provider for IV therapy? Y or N

- What types of treatment have you tried for this problem?

☐ Acupuncture	☐ Homeopathy	☐ Physiotherapy	☐ Traditional Chinese Medicine
☐ Chiropractic	☐ Massage	☐ Osteopathy	☐ Energy work
☐ Diet change	☐ Pharmaceutical Drugs	☐ Supplements	☐ Other _____
☐ Herbs		☐ Psychotherapy	

Outcome: _____

4. Other current health issues in order of importance to you: Date began? Are you being treated for this?

_____

_____

_____

5. List all **current** medications and dose (prescribed or over the counter): Since? Adverse effects?

Medication	Dose and frequency	Since When	Adverse Effects?

Other: _____

6. List all supplements you are currently taking and dosages:
(Vitamins, minerals, enzymes, homeopathic, herbs, etc.)

Supplement, Brand	Dose and frequency	Since When

7. Do you have any anaphylactic allergies? _____

8. Do you have any allergies to: medications, environmental substances (airborne, dust, pollens animals, chemicals) or foods? What kind of reactions to you experience? _____
_____

9. Do you have any food sensitivities? What kind reactions to you experience? _____
_____

10. List all major hospitalizations:
Year Operation/ Illness/ Injury Outcome
_____
_____
_____

11. Do you consider yourself: □ Underweight □ Overweight □ Just Right
□ I have noticed unintentional weight loss of 10 lbs. or more in the last 3 months
□ I have noticed unintentional weight gain of 10 lbs. or more in the last 3 months.
Your weight today: _____ Height: _____

12. Rate your current energy level from 1 to 10 with 1 being the lowest.
1 2 3 4 5 6 7 8 9 10

Lifestyle: Stress, Sleep, Exercise, Nutrition, Vices, Emotions

Stress, Pressures, and Coping and Emotional Health

1. Please circle the level of stress you are experiencing on a scale of 1 to 10, with 1 being the lowest.
1 2 3 4 5 6 7 8 9 10

2. Please identify the major causes of stress (job, family, finances, legal, health)
_____
_____

3. Do you feel you regularly experience:

☐ Anxiety ☐ Low Mood ☐ Excessive Worrying ☐ Overwhelmed

Sleep

1. How many hours do you sleep at night on average? _____
2. Do you feel rested when you wake up? Y or N
3. Do you have trouble: ☐ falling asleep ☐ Staying asleep? How many times do you wake up? _____

Exercise

In your estimation, how physically fit are you (please circle)?

☐ Unfit ☐ Below Average ☐ Average ☐ Above Average ☐ Very Fit

Nutrition/Hydration

1. Are following a diet plan? (Keto, Paleo, vegetarian, vegan) _____
2. Since when? _____
3. How many: Cups of water/day? _____
4. Do you cook? Y or N How often do you eat out per week? _____

Substances

1. Alcoholic beverages/week? _____
2. Caffeine: Cups of coffee, tea, pop/day? _____
3. Recreational drugs? Y or N If yes, which? How often? _____
4. Cannabis Use? Y or N What forms? _____
5. Do you smoke? Y or N If "yes" how much per day? _____ Please list past use; how much smoked daily for how long, and number of years quit: _____
6. Number of bowel movements per day or per week _____
7. Any conditions/occurrences from which you feel your health has never been the same since?

_____

Medical History

Please check the conditions you have had or continue to experience: **Specify (p) Past or (c) Current.**

- ☐ Abuse
- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Atypical Pap
- ☐ Auto Immune Disease
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Carpal Tunnel
- ☐ Chicken Pox
- ☐ Cholesterol Elevated
- ☐ Circulatory Problems
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Environmental Sensitivity
- ☐ Epilepsy
- ☐ Eyes, Ears, Nose, Throat Problems
- ☐ Gallstones
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Hay Fever
- ☐ Heart Attack

- ☐ Heart Valve Problem
- ☐ Hepatitis A B C
- ☐ Herpes: Oral/ Genital
- ☐ HIV
- ☐ Hypertension
- ☐ Infection- Chronic
- ☐ Irritable Bowel Syndrome
- ☐ Kidney or Bladder Disease
- ☐ Learning Disability
- ☐ Liver Disease
- ☐ Malaria
- ☐ Measles
- ☐ Mental Illness _____
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Neurological Problems
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Other _____
- ☐ Pacemaker
- ☐ Paralysis
- ☐ Parasites
- ☐ Parkinson's
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Prostatitis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seasonal Affective Disorder
- ☐ Sleep Apnea
- ☐ STD
- ☐ Stent
- ☐ Stroke
- ☐ Thyroid Issues
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary Tract Infections
- ☐ Varicose Veins
- ☐ Whoop

What vaccinations have you had? Any complications? _____

Current Medical Status

General

- ☐ Cold Intolerance
- ☐ Edema (Water Retention)
- ☐ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Fatigue
- ☐ Heat Intolerance
- ☐ Overweight
- ☐ Poor Sleep
- ☐ Recent Change in Appetite
- ☐ Recurrent Infections
- ☐ Sweat Easily
- ☐ Sweating at night
- ☐ Swollen Lymph Nodes
- ☐ Thirst - No Desire to Drink
- ☐ Underweight
- ☐ Other _____

Cardiovascular

- ☐ Blood Clots
- ☐ Chest pain
- ☐ Cold Hands/Feet
- ☐ Difficulty Breathing
- ☐ Fainting
- ☐ Heart Palpitations
- ☐ Irregular Heartbeat
- ☐ Swelling in Hands/Feet
- ☐ Other _____

Musculoskeletal

- ☐ Back Ache/Pain
- ☐ Hernia
- ☐ Joint Pain
- ☐ Muscle Pains
- ☐ Muscle Weakness
- ☐ Neck Ache/Pain
- ☐ Orthotics
- ☐ Stiffness
- ☐ Other _____

Behavioral

- ☐ Aggressive/Bad Temper
- ☐ Anxiety
- ☐ Depression
- ☐ Easily Stressed
- ☐ Fear
- ☐ High Pressure Job
- ☐ Moody
- ☐ Nervousness
- ☐ Overwhelm
- ☐ Panic Attacks
- ☐ Other _____

Gastrointestinal

- ☐ Bad Breath
- ☐ Belching
- ☐ Black Stools
- ☐ Bloody Stools
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/Bloating
- ☐ Hemorrhoids
- ☐ Indigestion/Heartburn
- ☐ Mucus in Stools
- ☐ Nausea
- ☐ Pain or Cramps
- ☐ Rectal Pain
- ☐ Sensitive Abdomen
- ☐ Use Laxatives
- ☐ Vomiting
- ☐ Other _____

Respiratory
- ☐ Coughing Blood
- ☐ Coughing Phlegm/Mucus
- ☐ Difficulty Breathing When Lying Down
- ☐ Postnasal Drip
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Tight Chest
- ☐ Wheezing
- ☐ Recurrent/Persistent Cough/Cold

Other _____

Neurological
- ☐ Loss of Balance/Coordination
- ☐ Nerve Damage
- ☐ Numbness/Tingling
- ☐ Tremors
- ☐ Twitching
- ☐ Vertigo
- ☐ Other _____

Skin
- ☐ Bleed or Bruise Easily
- ☐ Change in Colour of Mole
- ☐ Dandruff
- ☐ Dry Skin/Scalp
- ☐ Eczema
- ☐ Fungal Infection
- ☐ Hives
- ☐ Itching
- ☐ Loss of Hair
- ☐ Oily Skin/Scalp
- ☐ Pimples/Acne
- ☐ Rashes
- ☐ Recent Moles
- ☐ Ulcerations
- ☐ Other _____

Head, Eyes, Ears, Nose, Throat
- ☐ Bleeding Gums
- ☐ Blurry Vison
- ☐ Cataracts
- ☐ Color Blindness
- ☐ Concussions
- ☐ Dentures
- ☐ Dizziness
- ☐ Draining/Discharge from Ear
- ☐ Dry Mouth
- ☐ Dry Throat/Hoarseness
- ☐ Eye Pain
- ☐ Grinding Teeth
- ☐ Headaches
- ☐ Hearing Aid
- ☐ Jaw Clicks
- ☐ Mucus in Nose and Throat
- ☐ Night Blindness, Difficulty
- ☐ Nose Bleeds
- ☐ Poor Hearing
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Snoring
- ☐ Sores on Lips or Tongue
- ☐ Spots in Eyes/Floaters
- ☐ Teeth Problems
- ☐ Wear Glasses/Contacts
- ☐ Other _____

Genito-Urinary
- ☐ Blood in Urine
- ☐ Dribbling Urination
- ☐ Frequent Urination
- ☐ Impotency
- ☐ Kidney Stones
- ☐ Pain on Urination
- ☐ Unable to Hold Urine
- ☐ Urgency to Urinate
- ☐ Wake up to Urinate
- ☐ Other _____

Sexual Orientation (Optional)
- ☐ Asexual
- ☐ Bisexual
- ☐ Gay
- ☐ Hetero
- ☐ Lesbian
- ☐ Queer
- ☐ Transgender

Male
- ☐ Change in Sex Drive
- ☐ Discharge from Penis
- ☐ Infertility
- ☐ Lump in Testicles
- ☐ Pain in Testicles
- ☐ Prostate Abnormalities
- ☐ Varicocele
- ☐ Vasectomy

Other _____

Female
- ☐ Bleeding Between Periods
- ☐ Cervical Dysplasia
- ☐ Change in Sex Drive
- ☐ Discharge from Nipple
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Hysterectomy Full/Partial
- ☐ Infertility
- ☐ Insufficient Lactation
- ☐ Irregular Cycles Low or High
- ☐ Lumps in Breast
- ☐ Menopausal
- ☐ Midcycle Pains
- ☐ Ovarian Cysts
- ☐ Pain with Intercourse
- ☐ Painful Menstrual Periods
- ☐ PCOS
- ☐ Perimenopausal
- ☐ PMS
- ☐ Recent Change in Cycle
- ☐ Tendency to Miscarry
- ☐ Tubal Ligation
- ☐ Vaginal Discharge

- ☐ Vaginal Itching or Burning
- ☐ Other _____

Menstruation:
Last Menstrual Date:

_____

Cycle Length (days)

_____

# of days of bleeding: _____

Volume: # pads/day _____

PMS/Menstrual Symptoms

- ☐ Acne/Pimple Flare
- ☐ Back Pain
- ☐ Breast Tenderness
- ☐ Cramping
- ☐ Cravings
- ☐ Diarrhea/constipation
- ☐ Difficulty sleeping
- ☐ Fatigue
- ☐ Headaches, Migraines
- ☐ Mood Changes (Anger, Irritable, Sad, Sensitive
- ☐ To Hot/To Cold
- ☐ Water Retention
- ☐ Other _____

And finally, would you like to:

- ☐ Be Free of Pain
- ☐ Be Happier!
- ☐ Be less Indecisive
- ☐ Be Less Moody
- ☐ Be More Organized
- ☐ Be More Relaxed
- ☐ Better Body Odor
- ☐ Better Breath
- ☐ Feel More Motivated
- ☐ Get Rid of Allergies
- ☐ Have less Colds and Flus
- ☐ Have More Endurance
- ☐ Have More Energy/Stronger
- ☐ Improve Memory
- ☐ Increase Your Sex Drive
- ☐ Lose/Gain Weight
- ☐ Not Be Dependent on Over-The-Counter/Other Meds
- ☐ Reduce risk of Inherited Familial Disease Tendencies
- ☐ Sleep Better
- ☐ Stop Using Laxatives
- ☐ Think More Clearly
- ☐ Other: _____

Family History (indicate which family member)

- ☐ Arthritis
- ☐ Autoimmune Disease _____
- ☐ Asthma
- ☐ Alzheimer's Disease
- ☐ Bleeding Problems
- ☐ Cancer_____ _____
- ☐ Cardiovascular disease
- ☐ Cholesterol elevated
- ☐ Dementia
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Epilepsy
- ☐ Hay Fever, Allergies
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Mental Health Issues _____
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Substance Abuse _____
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Other _____

Important Office Policies

Privacy

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my record at any time and can request a copy of it by paying the appropriate fee. _____
Initial

I understand that information from my record may be analyzed for research purposes, and that my identity will be protected and kept confidential. _____
Initial

I have read the above information and with this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above except for: _____ ____
Initial

In Office Wait Times

We try our very best to keep appointments running on time which can be difficult in a health care setting. At times there are unexpected complexities, urgencies and needs that can affect the scheduling.

Email Policy

We do very much want to know how you are doing and any concerns you may have – alas we cannot address such concerns by email.

Initial Consent

I intend this consent form to cover the entire course of treatment for my present condition.
I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I have read and understand all this form, including the risks, alternatives for treatment, and the Village Centre for Integrative Medicine office policies.

Name (Print): _____

Signature: _____ Date: _____/_____/_____
(Guardian if applicable) mm dd yyyy