CARDEA HEALTH integrative

Basic Evaluation for IV Therapy

Name: **DOB:** **Date:**

Address: **Phone #:**

Emergency contact:

Name:

How did you hear about us? **Relationship:**

Phone #:

Reason for visit:

Medical / Surgical history:

Are you, or could you be, pregnant or breastfeeding? (Y/N)

Food/Drug Allergies:

Reaction:

Have you ever had an intolerance to vitamins/minerals?

Medications

Name:	Dose:	Frequency:

Supplements

Type:	Dose:	Frequency:

Hours of sleep at night: **Exercise:** **Diet:**

Caffeine intake: **Coffee / Tea** **Cups per day:**

Abbreviated Physical Exam:

Approved by Medical Staff?