Date: ____________

IV Intake form

Dr. Katie Coombs, ND

Legal name:____ D.O.B___________________

Preferred name:______________________________ Age:_______ Sex: **F or M** (circle one)

Address:____

City:_________________________ Prov:_____________ Postal Code:____________________

Tel (home):_______________________ Tel (alt):_____________________________________

Email:____ Marriage status:_______________

Personal Health Number:___________________________

Medical Doctor:____________________________ Phone:_____________________________

Emergency Contact:__________________________Phone:_____________________________

How did you hear about us?____

Health Information

Reasons for wanting IV therapy:____

Height:___________________ Weight:_______________

List any known or suspected allergies: ____

____

List any medical conditions:____

____

List any hospitalizations (surgeries/ emergency visits):______________________________

____

List any other health related concerns:____

____

____

List any prescription drugs you are presently taking:_______________________________

____

Have you had intravenous treatment before, if yes, what was your experience with it?_____

____

Thank you for your time in filling out this form. Reverse side is for the doctor to fill out in your visit.

IV Therapy Intake Form

Medical disorders:

Kidney function: Recent testing________________ Results______________________________________

Any urination problems:____

Any lower back pain:____

Urine strip: glucose:________________________, protein:______________________

Liver function: Recent Testing:______________ Results:______________________________________

Any digestive problems:____

Skin color____

RUQ pain:____

Heart function: Recent testing:_________________ Results:___________________________________

Blood pressure:________________ HR:_________________ Rhythm______________

Skin color/temperature at feet/ ankles:___________________________________

Posterior tibial and dorsal pedal pulses:__________________________________

Hx of raynauds:____

Blood disorder: Thalessemia:_______________ G6PD:_____________ Spherocytosis:___________

Sickle cell:_______________ Clotting:_____________

Neurological: Recent testing:_________________Results:____________________________________

Numbness or tingling:____

Sensitivity to sharp/ dull on feet:____

Blood sugar: Recent testing:________________ Results:_____________________________________

Any between meal symptoms?____

RBS:_______________ Time taken:_____________________ Last Meal:____________

I have filled out the preceding paperwork honestly and to the best of my knowledge. I have answered the questions honestly as presented on this page. I have reviewed the information on this page and agree that any information that I have given is reflected in the answers on this page as filled out by the practitioner conducting the interview. I understand that false answers may lead to complications in my treatment.

Patient Signature:____