Intake Questionnaire **J Glow IV Hydration & Wellness**

Date: _____

Name: _____ DOB:_____ Age: _____

Address:

_____

_____

Phone: _____Email: _____

Reason for visit:

_____

Emergency Contact:

_____

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)

_____

_____

_____

_____

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Please check any conditions that apply to you:

CARDIOVASCULAR AND RESPIRATORY

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

GASTROINTESTINAL AND URINARY

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

METABOLIC/ENDOCRINE/AUTOIMMUNE

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

NEUROLOGIC

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

HEMATOLOGY

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

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

PSYCHOLOGICAL
☐ Depression
☐ Anxiety or Panic Attacks
☐Suicidal Ideations

CANCER
☐ Location of cancer _____
☐Chemotherapy
☐Radiation

WOMEN (non-menopausal)
Last Menstrual Period _____ Any chance that you are pregnant? _____
Are you currently breastfeeding? _____

PAIN
☐CRPS
☐Fibromyalgia

Do you drink alcohol or use any illicit 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 regarding your health?

_____
_____
_____
_____

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

_____
Signature Date

_____
Print name