

Providing integrative and functional medical treatments supporting long-term health and vitality to regenerate and renew every cell of your body.

***Let's Improve Your Health and Vitality Together!***

### INTRAVENOUS NUTRIENT THERAPY INTAKE FORM

Patient Information:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (other) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F \_\_\_\_\_

Occupation: \_\_\_\_\_

Email address: \_\_\_\_\_

In case of Emergency please contact: \_\_\_\_\_

Name:

Phone:

How did you hear about us?  Internet  Facebook  Walk-in  Friend

**What are your main complaints?** (Please check all that apply)

- Fatigue or low energy
- Stress
- Poor diet due to busy lifestyle
- Brain fog or trouble concentrating
- Low mood or depression
- Cold or flu symptoms
- Facial wrinkles or fine lines
- Dull or dry skin
- Malabsorption issues
- Other \_\_\_\_\_



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**Which statements best describe why you are here today?** (Please check all that apply)

- I want to have more energy and feel better overall
- I want to do everything I can to nourish my body
- I want to do everything I can to enhance my weight loss efforts
- I want to prevent getting sick
- I want to recover quickly from my surgery or illness
- I want to slow the aging process
- I want to feel and look younger
- I want to have smoother, brighter and more vibrant skin
- I want to cleanse my body of toxins
- I want to recover quickly from a hangover
- Other \_\_\_\_\_

### **MEDICAL HISTORY**

Are you pregnant or breastfeeding?  Yes /  No

Date of last chemistry screen or other lab testing \_\_\_\_\_

Have you ever been told that you have an electrolyte imbalance or other abnormal labs?

Yes /  No

(Please check all that apply)

- Hypermagnesemia (High magnesium levels)
- Hypercalcemia (High calcium levels)
- Hypokalemia (Low potassium levels)
- Hemochromatosis (High iron levels)
- Other \_\_\_\_\_

Are you a diabetic?  Yes /  No

Are you a smoker?  Yes /  No

If Yes, how much do you smoke? \_\_\_\_\_

How many alcoholic drinks do you consume in a week?

\_\_\_\_\_

Do you use any recreational drugs?  Yes /  No



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If Yes, which ones and how often?

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**Please list everything you are currently taking:**

Prescription Medications – Strength – Frequency-Condition being treated

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Over the Counter Drugs – Strength – Frequency – Condition being treated

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Vitamins and Other Supplements – Strength – Frequency – Condition being treated

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### **MEDICAL HISTORY CONTINUED**

Do you take Digoxin (Lanoxin) for a heart problem?  Yes /  No

Do you take any diuretics or water pills?  Yes /  No

If Yes, please list: \_\_\_\_\_

Do you take any steroids, i.e. Prednisone?  Yes /  No

If Yes, please list: \_\_\_\_\_

Do you have any medication or food allergies?  Yes /  No

If Yes, please list: \_\_\_\_\_

Do you have any of the following conditions? (Please check all that apply)

- Blood pressure problems (High or low)
- Heart Problems
- Stroke or “mini-stroke”
- Kidney Problems

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- Kidney Stones
- Asthma
- Sickle Cell Anemia
- G6PD Deficiency
- Sarcoidosis
- Parathyroid problems (High levels)

List any other medical conditions you have (not mentioned above):

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List of all surgical procedures you've had with approximate dates:

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Is there anything else you'd like the physician to know?

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## **IV Nutrient Therapy**

### **Checklist of what to bring:**

- Your completed Intravenous (IV) Infusion Therapy Intake Form
- A list of all prescription medications, OTC medications, vitamins/supplements that you take
- A copy of your most recent bloodwork is helpful
- Your signed Consent Form
- Your signed HIPAA Notice
- Make sure you are well hydrated prior to your visit. We suggest drinking 1-2 16 oz. bottles of water. Dehydration can make it difficult to insert an IV.
- Make sure you eat something prior to your visit. We suggest a high protein snack, such as nuts, seeds, a protein bar, cheese, yogurt or eggs. Low blood sugar can make you feel weak, lightheaded or dizzy.

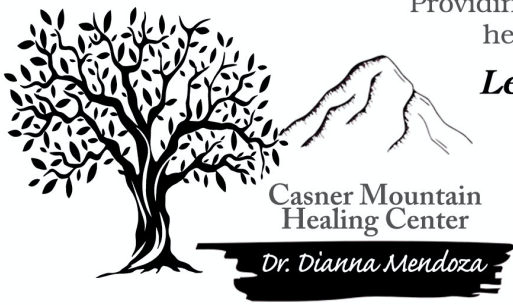
### **During your first visit for IV Vitamin Therapy infusions:**

During the first visit, Dr. Mendoza will discuss your main complaints and desired outcomes with you. Dr. Mendoza will review your medical & surgical history and any medications you are taking.

Based on this assessment, your Intravenous (IV) infusion will be customized to address your individual needs.

What to expect: The IVs used during your Intravenous (IV) infusion therapy are exactly the same that you would find in a hospital. Instead of a clinical experience though, our IV infusions are given in a peaceful spa setting and leave you feeling calm, relaxed, and refreshed.

All of our infusions last from 45-60 min. Our friendly and attentive staff will keep you calm, cared for, and comfortable during your infusion. Patients find the experience tranquil and healing. Patients leave feeling vibrant, energized, and refreshed.



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### **Intravenous (IV) Nutrient Therapy Consent Form**

This document is intended to serve as informed consent for your Intravenous (IV) Nutrient Therapy as ordered by Dr. Mendoza of Casner Mountain Healing Center. (Initials) \_\_\_\_\_

I have informed the physician of any known allergies to medications or other substances and of all current medications and supplements. (Initials) \_\_\_\_\_

I have fully informed the physician of my medical history. (Initials) \_\_\_\_\_

Intravenous infusion therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any medical disease. (Initials) \_\_\_\_\_

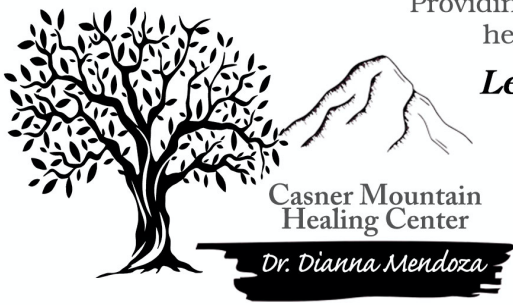
These IV infusions are not a substitute for your physician's medical care. (Initials) \_\_\_\_\_

I understand that IV Nutrient Therapy at Casner Mountain Healing Center is only for otherwise healthy adults or has been authorized by Dr. Mendoza. (Initials) \_\_\_\_\_

I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent. (Initials) \_\_\_\_\_

I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.
3. Risks of intravenous therapy include but not limited to:
  - a) Occasionally: Discomfort, bruising and pain at the site of injection.
  - b) Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
  - c) Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.
4. Benefits of intravenous therapy include:
  - a) Injectables are not affected by stomach, or intestinal absorption problems.
  - b) Total amount of infusion is available to the tissues.
  - c) Nutrients are forced into cells by means of a high concentration gradient.



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d) Higher doses of nutrients can be given than possible by mouth without intestinal irritation.  
(Initials)\_\_\_\_\_

I am aware that other unforeseeable complications could occur. I do not expect the physician(s) to anticipate and or explain all risk and possible complications.

I rely on the physician(s) to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered. (Initials)\_\_\_\_\_

I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance.

My signature on this form affirms that I have given my consent to IV Nutrient Therapy, including any other procedures which, in the opinion of my physician(s) or other associated with this practice, may be indicated.

My signature below confirms that:

1. I understand the information provided on this form and agree to the all statements made above.
2. Intravenous (IV) Nutrient Therapy has been adequately explained to me by my physician.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of Intravenous (IV) Nutrient Therapy.

Patient's Name and Date of Birth – Please Print

\_\_\_\_\_

Patient's Signature and Date

\_\_\_\_\_

Physician's Name – Please Print

\_\_\_\_\_

Physician's Signature and Date

\_\_\_\_\_