Vital Flow PLLC
1120 E. Elizabeth Street, Ste G2
Fort Colling, CO 80524

Intake Questionnaire

Date: _____

Name: _____ DOB:_____ Age: _____

Address:_____

Phone: _____Email: _____

Reason for visit: _____

Emergency Contact:
_____
Are you under the care of a primary care provider?_____

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? _____

Allergies (Medications, foods, etc.):
_____

Current Medications: (Please include OTC & supplements)
_____
_____

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
- ☐ Bladder Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Hepatitis A, B, C
- ☐ 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 – attach lab results
□ G6PD Deficiency – attach lab results

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 (complex regional pain) related to injury lasting longer than expected
□Fibromyalgia

Do you drink alcohol or abuse any types of 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?
_____
_____

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

_____
Signature Date

_____
Print name