IVC INFUSIONS LLC: NEW PATIENT INTAKE FORM

SECTION 1:
CONSENT TO TREAT

I understand that this is a Nutritional Infusion Center where I may receive treatment. I am aware that any type of standard of complementary treatments may have side effects. This center provides consultations and treatments for various conditions and diseases, including cancer. I understand that medical doctors providing cancer care, that acupuncture, naturopathic medicine; massage and Chinese Medicine treatments provided by this or any other center should not replace standard medical treatments. I also understand that I should tell my Medical Doctor about the treatments that I receive at this center.

I have read and understood the above statements.

Name:	Date: *(Example 10/10/2010)*

SECTION 2:
FINANCIAL POLICIES

In order to reserve the time for your initial appointment, we require a credit card on file. Appointment times are reserved specifically for you. If you fail to keep your appointment, the time cannot be utilized by other patients who are ill and need to be seen. To avoid charges, cancellations should be made at least 24 hours before the scheduled appointment, and whenever possible, 48 hours in advance. Payment for all services and dispensary items is due at the time of the visit. Our office accepts Visa, Master Card and debit cards as well as cash and checks. We do not send out bills.

IVC Infusions LLC does not bill insurance and is an "out of plan provider" for all insurance plans.

We will provide you with a day-of-service summary receipt that you can submit to your insurance company for reimbursement.

I have read and understood the above statements

Name:	Date: *(Example 10/10/2010)*

Continued on next page

IVC INFUSIONS LLC: REGISTRATION FORM

(Please print clearly for paper form submissions)

Today's Date: *(Example 10/10/2010)*	PCP:

SECTION 3:
PATIENT INFORMATION

NAME:	
Last Name:	
First Name:	
Date of Birth:	SS#:
Sex: Male ☐ Female ☐	Age:
Height:	Weight:
ADDRESS:	
Home:	
City:	State:
Zip:	
PHONE NUMBERS:	
Home:	Work:
Occupation:	
Employer:	

IN CASE OF EMERGENCY

Name of local Friend or Relative:	
Relationship to Friend or Relative:	
Home Phone:	Work Phone:

Parent/Guardian Signature:	Date: *(Example 10/10/2010)*

continued on next page

Name:	Today's Date: *(Example 10/10/2010)*

SECTION 4:

1.) What is the **main reason** for your visit today?

Please print or type the reason for your visit today

2.) Please **describe** major health problems, hospitalizations and surgeries:

2a.		2a. Date:	
2b.		2b. Date:	
2c.		2c. Date:	

3.) What **events** or **conditions** do you feel may have influenced, or aggravated your health conditions?

3a.	
3b.	
3c.	

4.) Please list any **allergies** you may have (environmental, food, medications, pets, etc.):

4a.	
4b.	
4c.	
4d.	

5.) What **supplements** (vitamins, minerals, herbs, etc.) do you take?

5a. Supplement Name:			
5a. Supplement Dose:		5a. Per Day:	

5b. Supplement Name:			
5b. Supplement Dose:		5b. Per Day:	

5c. Supplement Name:			
5c. Supplement Dose:		5c. Per Day:	

continued on next page

Name:	Today's Date:

6.) What **over-the-counter** medicines (like Tylenol, cough syrup, Advil, etc.) do you use?

6a. O-T-C Name:	
6a. O-T-C Dose:	6a. Per Day:

6b. O-T-C Name:	
6b. O-T-C Dose:	6b. Per Day:

6c. O-T-C Name:	
6c. O-T-C Dose:	6c. Per Day:

7.) Please list **prescription** medications:

7a. Prescription Name:	
7a. Prescription Dose:	7a. Per Day:

7b. Prescription Name:	
7b. Prescription Dose:	7b. Per Day:

7c. Prescription Name:	
7c. Prescription Dose:	7c. Per Day:

8.) Do / did you use **alcohol**? Yes ☐ No ☐
8a. If yes, how much / how often?

9.) Do / did you **smoke** cigarettes? Yes ☐ No ☐	
9a. If yes, how many per day?	9b. How many years?

10.) What kind of activity or **exercise** do you do?	
10a. How often?	10b. Days per week?

continued on next page

Name:	Today's Date:

11.) How much do you weigh?

11a. Is this your typical weight? Yes ☐ No ☐

12.) Have you experienced weight gain or loss recently? Yes ☐ No ☐

12a. Please describe is yes:

13.) Do you have any pets? Yes ☐ No ☐

13a. Please describe is yes:

14.) Do you have any plants? Yes ☐ No ☐

14a. Please describe is yes:

15.) On a scale of 1-10 (1 is the lowest, 10 is the highest), describe the level of stress you currently experience:

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐

16.) In what **areas** of life are you experiencing stress?

Family ☐	Money ☐	Relationship ☐	Work ☐	Health ☐	Children ☐

Other:

17.) Have you ever lived on/near a **farm?** Yes ☐ No ☐

17a. If yes, describe area:

17b. Length of time in area:

18.) Have you ever lived on/near a **orchard?** Yes ☐ No ☐

18a. If yes, describe area:

18b. Length of time in area:

continued on next page

Name:	Today's Date:

19.) Have you ever lived on/near a **forest service property?** Yes ☐ No ☐

19a. If yes, describe area:
19b. Length of time in area:

20.) Have you ever lived on/near a **industrial area?** Yes ☐ No ☐

20a. If yes, describe area:
20b. Length of time in area:

21.) Where did you grow up?

21a. City/Town	21b. Length of time in area:

22.) Parent's occupations?

22a. Mother:
22b. Father:

23.) Did your parents smoke?

23a. Mother ☐	23b. How long?	23c. Father ☐	23d. How long?

24.) Please describe when you have used antibiotics and why they were prescribed:

24a. Antibiotic Name:	
24a. Reason for use:	
24a. Date prescribed	24a. For how long?

24b. Antibiotic Name:	
24b. Reason for use:	
24b. Date prescribed	24b. For how long?

24c. Antibiotic Name:	
24c. Reason for use:	
24c. Date prescribed	24c. For how long?

SECTION 4:

Please check any health conditions or symptoms you have or had:

Check **C** for **current condition** and check **P** for **past condition**. Leave blank for never having the condition.

25.) Respiratory

C ☐	**P** ☐	Asthma
C ☐	**P** ☐	Chronic bronchitis
C ☐	**P** ☐	Emphysema
C ☐	**P** ☐	Wheezing
C ☐	**P** ☐	Trouble breathing/shortness of breath

26.) Endocrine

C ☐	**P** ☐	Hypothyroid
C ☐	**P** ☐	Hyperthyroid
C ☐	**P** ☐	Low blood sugar (hypoglycemia)
C ☐	**P** ☐	Fatigue
C ☐	**P** ☐	Diabetes (childhood onset)
C ☐	**P** ☐	Diabetes (adult onset)
C ☐	**P** ☐	Intolerance to heat or cold
C ☐	**P** ☐	Excessive hunger or thirst

27.) Skin

C ☐	**P** ☐	Rashes	
C ☐	**P** ☐	Acne / Boils	
C ☐	**P** ☐	Sunburn, # of times: ☐	Severity of burn: ☐
C ☐	**P** ☐	Eczema/hives/itching	
C ☐	**P** ☐	Hair loss	
C ☐	**P** ☐	Night sweats	

continued on next page

28.) Nose & Sinuses

C ☐	**P** ☐	Stuffiness /post nasal drip
C ☐	**P** ☐	Hayfever
C ☐	**P** ☐	Frequent sore throat
C ☐	**P** ☐	Sinus infections
C ☐	**P** ☐	Nose bleeds
C ☐	**P** ☐	Loss of change of sense of smell

29.) Cardiovascular

C ☐	**P** ☐	Heart disease
C ☐	**P** ☐	Heart attack
C ☐	**P** ☐	Angina / chest pain
C ☐	**P** ☐	High / Low blood pressure
C ☐	**P** ☐	High / Low cholesterol
C ☐	**P** ☐	Heart palpitations / heart murmur

30.) Immune System

C ☐	**P** ☐	Swollen glands
C ☐	**P** ☐	Frequent colds / flu
C ☐	**P** ☐	Chronic infections
C ☐	**P** ☐	Wounds heal slowly

31.) Neurological

C ☐	**P** ☐	Seizures
C ☐	**P** ☐	Pinched nerve
C ☐	**P** ☐	Dizziness or vertigo
C ☐	**P** ☐	Numbness / tingling in extremities

continued on next page

32.) Head

C ☐	**P** ☐	Headache
C ☐	**P** ☐	Migraines
C ☐	**P** ☐	Head injury
C ☐	**P** ☐	Jaw / TMJ problems

33.) Ears

C ☐	**P** ☐	Ringing in ears / tinnitus
C ☐	**P** ☐	Earaches
C ☐	**P** ☐	Ear infection / fluid in ear
C ☐	**P** ☐	Hearing loss

34.) Eyes

C ☐	**P** ☐	Spots in eyes / floaters
C ☐	**P** ☐	Cataracts
C ☐	**P** ☐	Eye strain /pain
C ☐	**P** ☐	Blurred vision
C ☐	**P** ☐	Eye surgery
C ☐	**P** ☐	Tearing of dry eyes
C ☐	**P** ☐	Glaucoma
C ☐	**P** ☐	Double vision
C ☐	**P** ☐	Color blindness
C ☐	**P** ☐	Macular degeneration
C ☐	**P** ☐	Detached retina
C ☐	**P** ☐	Glasses / contacts

continued on next page

35.) Mouth & Throat

C ☐	**P** ☐	Trouble / pain with swallowing	
C ☐	**P** ☐	Teeth grinding	
C ☐	**P** ☐	Gum problems	
C ☐	**P** ☐	Excessive saliva	
C ☐	**P** ☐	Hoarseness / loss of voice	
C ☐	**P** ☐	Mouth / tongue sores	
C ☐	**P** ☐	Dry mouth / decreased saliva	
C ☐	**P** ☐	Tooth loss	
C ☐	**P** ☐	Cavities	How many? ☐
C ☐	**P** ☐	Root canal	How many? ☐

36.) Gastrointestinal

C ☐	**P** ☐	Heartburn / reflux
C ☐	**P** ☐	Appetite changes
C ☐	**P** ☐	Gas / bloating / belching
C ☐	**P** ☐	Ulcer
C ☐	**P** ☐	Abdominal pain / cramps
C ☐	**P** ☐	Colon polyps
C ☐	**P** ☐	Gallbladder problems / gallstones
C ☐	**P** ☐	Liver problems
C ☐	**P** ☐	Constipation
C ☐	**P** ☐	Diarrhea
C ☐	**P** ☐	Nausea or vomiting
C ☐	**P** ☐	Vomiting blood

continued on next page

36.) Gastrointestinal (continued)

C ☐	**P** ☐	blood in stool
C ☐	**P** ☐	Changes in bowel movements
C ☐	**P** ☐	Hemorrhoids / rectal fissures
Do you have difficulty passing bowel movements? Yes ☐ No ☐		
Are your bowel movements: Soft ☐ Hard ☐ Liquid ☐ Formed ☐		

37.) Musculoskeletal

C ☐	**P** ☐	Joint pain or stiffness	
C ☐	**P** ☐	Leg pain	
C ☐	**P** ☐	Muscle cramps or spasms	
C ☐	**P** ☐	Back pain	
C ☐	**P** ☐	Neck pain	
C ☐	**P** ☐	Back surgery	
C ☐	**P** ☐	Arthritis	
C ☐	**P** ☐	Muscle weakness	
C ☐	**P** ☐	Sciatica	
C ☐	**P** ☐	Car accident?	How many?
C ☐	**P** ☐	Osteoporosis	
C ☐	**P** ☐	Broken bones	

38.) Urinary

C ☐	**P** ☐	Pain with urination
C ☐	**P** ☐	Increased urinary frequency
C ☐	**P** ☐	Increased urinary urgency
C ☐	**P** ☐	Kidney stones

continued on next page

38.) Urinary (continued)

C ☐	**P** ☐	Frequency at night
C ☐	**P** ☐	Frequent infections

39.) Blood / Peripheral Vascular

C ☐	**P** ☐	Blood clots
C ☐	**P** ☐	Phlebitis
C ☐	**P** ☐	Easy bleeding / bruising
C ☐	**P** ☐	Deep leg pain
C ☐	**P** ☐	Swollen ankles
C ☐	**P** ☐	Rheumatic fever
C ☐	**P** ☐	Anemia
C ☐	**P** ☐	Cold hands / feet
C ☐	**P** ☐	Anti-clotting medication

40.) Mental / Emotional

C ☐	**P** ☐	Mood swings
C ☐	**P** ☐	Trouble concentrating
C ☐	**P** ☐	Depression
C ☐	**P** ☐	Anxiety / Nervousness
C ☐	**P** ☐	Memory problems

41.) Men's Health

C ☐	**P** ☐	Hernias
C ☐	**P** ☐	Testicular masses
C ☐	**P** ☐	Testicular or groin pain
C ☐	**P** ☐	Prostrate problems

continued on next page

41.) Men's Health (continued)

C ☐	**P** ☐	Discharge or sores
C ☐	**P** ☐	Impotence / erectile dysfunction
C ☐	**P** ☐	Premature ejaculation
C ☐	**P** ☐	Sexually transmitted infection

42.) Women's Health

C ☐	**P** ☐	Irregular cycles
C ☐	**P** ☐	Heavy bleeding
C ☐	**P** ☐	Bleeding between cycles
C ☐	**P** ☐	Premenstrual syndrome
C ☐	**P** ☐	Cramping with menses
C ☐	**P** ☐	Menopausal symptoms
C ☐	**P** ☐	Breast lumps
C ☐	**P** ☐	Abnormal PAP
C ☐	**P** ☐	Endometriosis
C ☐	**P** ☐	Ovarian cysts
C ☐	**P** ☐	Uterine fibroids
C ☐	**P** ☐	Painful intercourse
C ☐	**P** ☐	Sexually transmitted infection
C ☐	**P** ☐	Difficulty conceiving
C ☐	**P** ☐	Hysterectomy
C ☐	**P** ☐	Cervical dysplasia

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43.) Sexual Health

Are you sexually active? Yes ☐ No ☐	
What form of birth control do you use?	
Do you do self-breast exams? Yes ☐ No ☐	
Do you get regular mammograms? Yes ☐ No ☐	
Do you wear a seat belt? Yes ☐ No ☐	

44.) Childhood Illnesses - Check all that apply

44a. Chicken Pox ☐	44b. Mumps ☐	44c. Scarlet Fever ☐
44d. Diphtheria ☐	44e. Measles ☐	44f. Polio ☐

45.) Has anyone in your family had any of the following:

45a. Cancer ☐	45b. High blood pressure ☐
45c. Diabetes ☐	45d. Heart disease or stroke ☐

46.) Has anyone in your family had any of the following:

Cancer: ☐			High blood pressure ☐		
Diabetes ☐			Heart disease or stroke ☐		
Which member / members of your family? *(check all that apply)*					
Mother ☐	Father ☐	Sibling ☐	Grandparent ☐	Aunt/Uncle ☐	Cousin ☐

SECTION 5:
CANCER INFORMATION:

47.) Patient Name:

47a. *(Please print full name)*	47b. D.O.B. *(Example 10/10/2010)*

48.) What **type** and **stage** of cancer have you been diagnosed with?

48a. Type: *(Please bring pathology report and recent lab work to your first office visit)*	48b. Stage:

49.) Is the **tumor**:

49a. Estrogen receptor positive (ER+): Yes ☐ No ☐	49b. Not applicable: ☐
49c. Progesterone receptor positive (PR+): Yes ☐ No ☐	49d. Not applicable: ☐

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WHAT CONVENTIONAL TREATMENTS HAVE YOU USED OR WILL USE?

50.) Surgery:

50a. Surgery name:	50a. Not recommended:
50a. Areas:	50a. Dates

50b. Surgery name:	50b. Not recommended:
50b. Areas:	50b. Dates

50c. Surgery name:	50c. Not recommended:
50c. Areas:	50c. Dates

51.) Chemotherapy:

51a. Name of drug:	51a. Not recommended:
51a. Date started or will start:	51a. Number of cycles:
51a. To be done every: *(_____ weeks)*	51a. Total weeks:

51b. Name of drug:	51b. Not recommended:
51b. Date started or will start:	51b. Number of cycles:
51b. To be done every: *(_____ weeks)*	51b. Total weeks:

52.) Radiation:

52a. Area irradiated:	52a. Not recommended:
52a. Date started or will start:	52a. Total # of treatments:

52b. Area irradiated:	52b. Not recommended:
52b. Date started or will start:	52b. Total # of treatments:

53.) Hormone treatments:

53a. Hormones / drug name:	53a. Not applicable:
53a. Date started or will start:	53a. Total weeks:

53b. Hormones / drug name:	53b. Not applicable:
53b. Date started or will start:	53b. Total weeks:

continued on next page

54.) Side effects of conventional treatments:

54a. Side effect: *(please describe)*	
54a. Date side effect experienced:	
54a. Concerns you have about side effect:	

54b. Side effect: *(please describe)*	
54b. Date side effect experienced:	
54b. Concerns you have about side effect:	

54c. Side effect: *(please describe)*	
54c. Date side effect experienced:	
54c. Concerns you have about side effect:	

55.) List **other treatments** you are using or have used for your cancer: *(herbs, supplements, vitamins, enzymes, etc.)*

55a. *(please describe):*	
55b. *(please describe):*	
55c. *(please describe):*	
55d. *(please describe):*	

56.) Your **Present** Oncology Care:

56a. Oncologist's name:	
56a. Hospital/Practice address: Name	
56a. Hospital/Practice address: Street	
56a. Hospital/Practice address: City	
56a. Hospital/Practice address: State	
56a. Hospital/Practice Phone:	
56a. Hospital/Practice Fax:	

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IVC INFUSIONS LLC: REGISTRATION FORM

(Please print clearly for paper form submissions)

SECTION 6:
PRESCRIPTIONS & SUPPLEMENTS

Name:	Date: *(Example 10/10/2010)*

57.) List any drug and known allergies:

57a.	
57b.	
57c.	
57d.	
57e.	
57f.	
57g.	

58.) List all prescriptions you are on:

58a. Name of drug:	
58a. Strength / Dosage:	
58a. Times a day	

58b. Name of drug:	
58b. Strength / Dosage:	
58b. Times a day	

58c. Name of drug:	
58c. Strength / Dosage:	
58c. Times a day	

58d. Name of drug:	
58d. Strength / Dosage:	
58d. Times a day	

continued on next page

59.) List every vitamin / mineral you are taking:

59a. Name of vitamin / mineral:	
59a. Strength / Dosage:	
59a. Times a day	

59b. Name of vitamin / mineral:	
59b. Strength / Dosage:	
59b. Times a day	

59c. Name of vitamin / mineral:	
59c. Strength / Dosage:	
59c. Times a day	

59d. Name of vitamin / mineral:	
59d. Strength / Dosage:	
59d. Times a day	

MEDICAL HISTORY

60.) List all surgeries:

60a. Reason:			
60a. Year:		60a. Hospital:	

60b. Reason:			
60b. Year:		60b. Hospital:	

60c. Reason:			
60c. Year:		60c. Hospital:	

60d. Reason:			
60d. Year:		60d. Hospital:	

60e. Reason:			
60e. Year:		60e. Hospital:	

concluded on next page

61.) Please check any that apply:

☐	61a. High Blood Pressure
☐	61b. Heart Attack
☐	61c. Diabetes
☐	61d. Thyroid Disease
☐	61e. Hepatitis
☐	61f. Gallbladder Disease
☐	61g. Seizures
☐	61h. Dementia / Alzheimer
☐	61i. Osteoporosis / Arthritis
☐	61j. Stroke
☐	61k. Other: *(please explain)*

When you have finished filling out this form:

1) Press the "SAVE AS" button below

2) Enter your name for the TITLE and make sure to save it as a .pdf

"Save As" = Patient's Name.pdf

3) Create a new e-mail message

4) In the ADDRESS insert:

staff@ivcinfusions.com

5) In the SUBJECT put "New Patient Form"

6) ATTACH the .pdf file your just saved

7) Write a message to let IVC Infusions LLC know who you are

8) Remember, do not give out personal information in the message, this will be in your attached .pdf file

9) When we receive your e-mail, the staff at IVC Infusions LLC will call to verify

SAVE AS