# IV HYDRATION LOUNGE
## INTAKE & QUESTIONNAIRE

## PATIENT INFORMATION

**NAME:** ______________________ ______ ______________________
(First) (Middle Initial) (Last)

______________________ **DATE OF BIRTH:** ____ / ____ / ____
(Preferred Name/Nickname) (Month) (Day) (Year)

**SEX:** ☐ Male ☐ Female **E-MAIL:** ______________________

**ADDRESS:** ______________________ ______
(Apartment/Unit)

______________ ______ ______________
(City) (State) (Zip Code)

**PRIMARY PHONE:** (______) ______________ Confidential Voicemails Okay? ☐ Yes ☐ No

**SECONDARY PHONE:** (______) ______________ Confidential Voicemails Okay? ☐ Yes ☐ No

**EMPLOYMENT:** Are you currently employed? ☐ Yes ☐ No Employer: ______________

**PRIMARY CARE PROVIDER:** ______________________

## EMERGENCY CONTACT *In case of an emergency, please contact:*

NAME: ______________________ RELATIONSHIP: ______________

PRIMARY PHONE: (______) ______________ SECONDARY PHONE: (______) ______________

## TERMS & CONDITIONS

1. **Acknowledgement of Non-Insurance Coverage for Services Rendered & Payment:** *(Initials ________)*
   - All intravenous nutrient infusions and injections administered at PRO Medical's IV Hydration Lounge are considered investigational/experimental by the United States Food and Drug Administration for the treatment of medical conditions. Therefore they are not intended to diagnose, treat, cure or prevent disease.
   - These services are self-pay as they are not considered standard of care and are not billable to insurance.
   - I understand that this appointment will not be billed to insurance and that this requires my payment in full for all IV infusions and injection services.
   - I agree I will not submit a claim or request PRO Medical or their staff to submit a claim for the IV Lounge's services.
   - I understand that if I have been referred to PRO Medical's IV Hydration Lounge by another physician/provider I am aware this is not a continuity of care and PRO Medical will not bill insurance for these services.
2. **Cancellation Policy:** *(Initials ____________)*
   - I understand that PRO Medical's IV Hydration Lounge has a 24-hour cancellation policy and that a charge of $100 will be billed to me directly if I miss any infusion appointment or fail to provide the required 24-hour notice when cancelling an appointment. For any injection or booster appointment this is also applicable, at a charge of $25.
   - I further understand that arriving late to a scheduled appointment may result in a shortened or rescheduled appointment.


**PRO MEDICAL | 4455 148TH AVE NE, BELLEVUE, WA 98007 | 425.895.6505 | PROCLUB.COM**

## PATIENT QUESTIONNAIRE *Please check all that apply and fill out to the best of your ability*

What are your main health concerns and/or health goals? ______________________________

Do you have allergic reactions to medication, food, etc.? ☐ No ☐ Yes If yes, please explain: ______________________________

Have you ever had any problems with IV infusions/injections in the past? ☐ No ☐ Yes If yes, please explain: ______________________________

Are you taking any medications and/or supplements including prescriptions, over-the-counter medications, vitamins, minerals, herbs, and homeopathic remedies? ☐ No ☐ Yes If yes, please provide: ______________________________

My energy level typically runs around (1=lowest, 10=highest): __________

My stress level typically runs around (1=lowest, 10=highest): __________

## SOCIAL HISTORY INTAKE

Do you consume alcohol? ☐ No ☐ Yes If yes, how many drinks per week: __________

Do you consume tobacco? ☐ No ☐ Yes If yes, please provide amount/packs per day: __________

Do you consume cannabis? ☐ No ☐ Yes How often? __________ In what forms? __________

## HEALTH QUESTIONNAIRE

Do you have a history of heart disease such as coronary artery disease, congestive heart failure, irregular heart rhythms, heart palpitations, valvular heart disease, heart surgery or myocardial infarction? ☐ No ☐ Yes If yes, please explain: ______________________________

Do you have a history of any platelet or bleeding disorders, ulcers, blood clots, or are you taking any blood thinners? ☐ No ☐ Yes If yes, please explain: ______________________________

Do you have a history of kidney disease such as abnormal kidney function kidney failure, or dialysis? ☐ No ☐ Yes If yes, please explain: ______________________________

Have you had any recent dizziness, numbness or tingling or any vision or speech changes, or any headaches that were severe, sudden onset, or associated with vomiting or vision problems, or were different than prior headaches? ☐ No ☐ Yes If yes, please explain: ______________________________

***Health Questionnaire continued...***

Are you experiencing any abdominal pain or chest pain, any shortness of breath, swelling of your legs, fevers, or have you been vomiting blood or noticing any blood in your stool? ☐ No ☐ Yes If yes, please explain: ____________________

Have you experienced excessive thirst or hunger, increased urination, or have a history of diabetes or high blood sugar? ☐ No ☐ Yes If yes, please explain: ____________________

Have you experienced any recent injuries or trauma or experienced any unexplained bleeding or bruising? ☐ No ☐ Yes If yes, please explain: ____________________

Have you ever been told that you should not receive IV fluids for any reason? ☐ No ☐ Yes If yes, please explain: ____________________

Have you, in the last 48-hours, participated in strenuous activity such as marathons, triathlons, etc.? ☐ No ☐ Yes If yes, please explain: ____________________

Have you ever had an allergic or adverse reaction to Zofran (Ondansetron)? ☐ No ☐ Yes If yes, please explain: ____________________

Have you ever had an allergic reaction to any vitamins? ☐ No ☐ Yes If yes, please explain: ____________________

Have you ever had an adverse reaction to a medicine a doctor gave you for numbing? Examples include, but are not limited to, lidocaine, procaine or ethyl chloride spray. ☐ No ☐ Yes If yes, please explain: ____________________

**CHECK ALL THAT APPLY TO YOU CURRENTLY:**

- ☐ Low energy/fatigue
- ☐ Swollen/sore tongue
- ☐ Tingling/numbness in hands/ feet
- ☐ Memory loss/dementia/Alzheimer's
- ☐ Poor focus and/or brain fog
- ☐ Infertility
- ☐ Low mood/depression
- ☐ Irritability
- ☐ Skin unusually pale
- ☐ Skin inside mouth unusually pale
- ☐ Poor sleep quality and/or length
- ☐ Experience dizziness/ lightheadedness
- ☐ Brittle nails/hair
- ☐ IBS/Crohn's/Celiac disease
- ☐ Indigestion/gas/bloating/other GI issues
- ☐ Cold hands/feet
- ☐ Difficulty walking
- ☐ Shortness of breath with minimal exertion
- ☐ Frequent headaches
- ☐ Easy bruising
- ☐ Frequently sick
- ☐ Diabetes
- ☐ Frequent poor diet choices
- ☐ High stress levels
- ☐ Weight gain and/or inability to lose weight
- ☐ Unexplained weight loss
- ☐ PMS/other hormonal imbalance
- ☐ Anxiety
- ☐ Anemia (Iron or Pernicious)
- ☐ Liver disease
- ☐ High levels of homocysteine in blood
- ☐ Poor recovery/healing wounds/illness following exercise
- ☐ Pregnant/Nursing
- ☐ Taking an anti-seizure medication
- ☐ A vegan/vegetarian
- ☐ On acid blocking medication/PPI
- ☐ An athlete/exercise frequently
- ☐ Diagnosed with neuropathy
- ☐ On a detox
- ☐ Positive for MTHFR genetic polymorphism
- ☐ NONE OF THE ABOVE

## SIGNATURE

**AGREEMENT:** By signing below, I certify that I have read and fully understand the information contained above, and agree to each of its terms. I have signed this before any item or service has been provided to me. I am not currently facing an emergency or urgent health care situation. I have had sufficient opportunity to discuss the information, ask questions, and obtain explanations, and the explanations were made to my satisfaction. I fully understand such explanations.

| ____________________ | ____________________ | ______ / ______ / ______ |
|---|---|---|
| **PATIENT NAME** | **PATIENT SIGNATURE** (AGE 18 OR OLDER) | **MONTH** **DAY** **YEAR** |