urban
INTEGRATIVE IV AND DETOX CLINIC

615 Yonge Street, 6th Floor
Toronto, Ontario, M4Y 1Z5
Phone: (416)463-2911 • Fax 1-(888)-676-2476
Website: www.urbaniv.com • Email: info@urbaniv.com

INTRAVENOUS (IV) INFUSION THERAPY INTAKE AND MEDICAL HISTORY FORM

Name		Date	
Address			
City	Province	Postal Code	
Phone: Home	Cell	Other	
Date of Birth (MM/DD/YY)		Age	Sex M / F
Occupation		Email address	
In case of emergency, please contact: Name		Phone	

How did you hear about us? ☐ Internet ☐ Social Media ☐ Walk-in ☐ Friend or family: _____

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

☐ Fatigue or low energy
☐ Stress
☐ Poor diet due to busy lifestyle
☐ Brain fog or trouble concentrating
☐ Low mood or depression
☐ Headaches or migraines
☐ Weight gain or difficulty losing weight
☐ Slow metabolism
☐ Asthma and Allergies
☐ Recent surgical procedure
☐ Recent illness
☐ Cold or flu symptoms
☐ Facial wrinkles or fine lines
☐ Dull or dry skin
☐ Skin hyperpigmentation (i.e. melasma)
☐ Malabsorption issues
☐ Other – specify _____

Name of Personal Physician _____
Phone Number _____
Date of Last Office Visit _____
Have you had laboratory testing or blood within the last year? YES ☐ NO ☐
Date of last laboratory 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 or hemosiderosis (High iron levels)
☐ Other – specify _____

Have you had an IV before? YES ☐ NO ☐

Are you pregnant or breastfeeding? YES ☐ NO ☐ Initials _____

Please use extra paper as needed

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

- ☐ Blood pressure problems (high or low)
- ☐ Heart Problems or Heart Failure
- ☐ Previous Heart Attack
- ☐ Stroke or "mini-stroke"
- ☐ Bleeding problems, Hemophilia or von Willebrand Disease
- ☐ Kidney Problems
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Conditions
- ☐ Asthma
- ☐ Pleural Effusions
- ☐ Optic Nerve Atrophy or Leber's Disease
- ☐ Sickle Cell Anemia
- ☐ Sarcoidosis
- ☐ Parathyroid problems (High levels)
- ☐ Allergies to drugs – if YES, specify _____
- ☐ Allergies to foods – if YES, specify _____
- ☐ Allergies to chemicals – if YES, specify _____
- ☐ Allergies to supplements – if YES, specify _____
- ☐ Allergic to sulpha, sulphites, sulphur? – if YES, specify _____
- ☐ ****Please check here if you attest to having none of the above***

If you have an allergic reaction to any of the above, please give details _____

_____

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

_____

Are you a diabetic? YES ☐ NO ☐ If YES, is your diabetes under control? YES ☐ NO ☐

Are you a smoker? YES ☐ NO ☐

If YES, how much do you smoke per day? _____ How many years? _____

How many alcoholic drinks do you consume in a week? _____

Do you use any recreational drugs? YES ☐ NO ☐ If YES, which ones and how often?_____

_____

Have you ever fainted? YES ☐ NO ☐ If YES, please give details _____

_____

Check any of the following that you are currently taking:

( ) Laxatives ( ) Cortisone ( ) Tranquilizers ( ) Thyroid Medication ( ) Diet Pills

( ) Pain Relievers ( ) Appetite suppressants ( ) Antacids ( ) Antibiotics ( ) Dioxin

( ) Steriods ( ) Diuretics (e.g. HCTZ, Lasix) ( ) Aspirin or other blood thinner medications

OVER THE COUNTER DRUGS – Name – Strength – Frequency – Condition being treated

_____

_____

VITAMINS AND OTHER SUPPLEMENTS – Name – Strength – Frequency – Condition being treated

_____

_____

Is there anything else you would like our medical staff to know about you or your health concerns?

_____

_____

I affirm that I have answered the above questions and statements truthfully and to the best of my knowledge.

Patient's Signature _____ Date _____