Intake Questionnaire

Date:

Name: DOB: Age:

Address:

Phone: Email:

Reason for visit:

Emergency Contact:

Allergies (Medications, foods, etc.):

Current Medications: (Please include OTC & supplements)

Please check any conditions that apply to you:

CARDIOVASCULAR AND RESPIRATORY

☐	High Blood Pressure	☐	Asthma
☐	Heart Murmur	☐	COPD
☐	Valve Disorder	☐	Sleep Apnea
☐	Abnormal Rhythm	☐	Shortness of Breath
☐	Chest Pain	☐	Pulmonary Hypertension
☐	Heart Attack	☐	Lung Cancer
☐	Cardiac Surgery/Stents		Other Lung Disorder

- [ ] Congestive Heart Failure
- [ ] Peripheral Artery Disease
- [ ] Thrombosis or DVT
- [ ] Aneurysm
- [ ] 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
- [ ] Diabetes Type I Type II
- [ ] Lupus
- [ ] ArthritisRheumatoid
- [ ] Hx of DKA
- [ ] Other ______

NEUROLOGIC

- [ ] Stroke/TIA
- [ ] Multiple Sclerosis
- [ ] Seizures Date of last seizure ______
- [ ] Parkinson's
- [ ] Alzheimer's

HEMATOLOGY

- [ ] Anemia (Iron Deficiency, Pernicious, Aplastic, Hemolytic, Sickle Cell)
- [ ] MTHFR
- [ ] G6PD Deficiency

MUSCULOSKELETAL

- [ ] Back Pain
- [ ] Carpal Tunnel Syndrome
- [ ] Fibromyalgia
- [ ] Degenerative Joint Disease
- [ ] Degenerative Disk Disease
- [ ] 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

☐ 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?

How did you hear about us?

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

Signature ______________________ Date __________

Print name ______________________

IV Infusion and Injection Consent Form

This form outlines that you understand that a peripheral intravenous catheter will be inserted into a vein in your body, and you will have fluids, vitamins, minerals, nutrient, and/or medications infused directly into your body. This is considered "IV Infusion Therapy." If you are having injection therapy, then you understand that a vitamin, mineral, nutritional compound, and/or medication will be injected directly into the subcutaneous fat or muscle of your body. This is considered "Injection Therapy."

Please initial each point bellowing acknowledging that:

☐ I understand that IV infusion and injection therapy at Pinnacle Performance Care is not intended to diagnose or treat a specific medical condition.

☐ I understand that IV infusion and injection therapy will not prevent, treat, or cure and medical condition or disease. Furthermore, I understand that I am here seeking IV infusion and/or injection therapy voluntarily to assist with certain symptoms or ailments I may be experience.

☐ I have informed (Insert clinic name, your name, nurses name) of all the medications, supplements, and allergies that I have. I understand that serious adverse events could happen if I do not disclose all of my drug/food/vitamin/and additional allergies and medications/supplements that I am currently taking.

☐ I understand that IV and injectable therapy and any claims made about these treatments 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. I understand that these treatments are not FDA approved for any given indications of treatment and are not considered a medical necessity.

☐ I understand that I have been informed of the procedure involving IV infusion and injections, the alternative treatment options, and the risks and benefits of the mutually agreed upon treatment.

☐ I understand that the procedure involves inserting a needle into a vein or having a solution injected into my muscle or body fat.

☐ I understand that common risks involved with IV and injection therapies include, but are not limited to, irritation, pain, discomfort, bruising, and bleeding at the site of the IV insertion or injection.

☐ I understand that less common risks involved with IV and injection therapies include, but are not limited to, infection at the site of the IV insertion or injection, injury to the tissue, phlebitis, low blood pressure, fainting, fluid volume overload, medication interactions, and drops in blood sugar levels.

☐ I understand that rare side risks involved with IV and injection therapies include, but are not limited to, sepsis, severe allergic reactions, severe medication/supplement interactions, anaphylaxis, blood clots, shock, cardiac arrest, and death.

☐ I understand that the benefits of IV and injection therapies include, but are not limited to, enhanced absorption of vitamins and minerals as they bypass the digestive tract, increased total body hydration, alleviation of certain symptoms, increased total body nutrient density, and improved performance/recovery.

☐ I affirm that I am voluntarily seeking IV infusion and injection therapies at Pinnacle Performance Care and have not been coerced into doing so.

☐ I understand the risks and benefits of the procedure, IV infusion therapy, and injection therapy and have had all my questions answered to my full satisfaction.

☐ I understand that unforeseeable complications can arise when an IV is placed and medications/fluids/minerals/vitamins are infused into the body.

☐ I understand that I have the right refuse any treatments or treatment recommendations at any time.

Final patient consent for treatment

- I have had the nature of the procedure and/or treatment, the benefits of treatment, the risks of treatment, the side effects, the alternative therapies for my medical condition or symptoms I am seeking treatment for, and the chances of treatment success explained to me. I have had all my questions and concerns answered to my satisfaction. I acknowledge that I have been given sufficient information about IV hydration/vitamin/mineral/nutrient infusion and injection therapy and all its associated risks and benefits upon which to make an informed decision about treatment.
- I acknowledge that there are no guarantees regarding the results of treatment and its effect on my presenting condition.
- I give my consent for the use of emergency intervention if required during treatment.
- I certify that I am of sound mind and body to make medical decisions and to consent for treatment.
- I certify I will continue to remain under the care a licensed and qualified primary care provider and/or mental health provider as IV infusion and injection therapy is considered an adjunctive and non-medically necessary treatment option, not a complete one.
- I release Pinnacle Performance Care and all the medical staff from all liabilities for any complications or damages associated with IV infusion and injection therapy.
- I have read this consent and fully understand the information within it and I voluntarily authorize and consent to the treatment options, including but not limited to IV infusion therapy, provided to me at Pinnacle Performance Care.

Indemnification Clause

I, ____________________ agree to indemnify, defend, protect, and hold harmless the medical providers employed by (PINNACLE PERFORMANCE CARE); and their respective officers, directors, employees, stockholders, assigns, successors and affiliates (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by (PINNACLE PERFORMANCE CARE); rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the medical providers employed by (PINNANCLE PERFORMANCE CARE); harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by (PINNANCLE PERFORMANCE CARE);. I am aware of the potential side effects associated with IV infusion and injectable therapies provided by (PINNANCLE PERFORMANCE CARE), accept all the risks involved with IV infusion and injectable therapies, and will not seek indemnification or damages from the indemnified parties.

Printed Name: ____________________

Signature: ____________________ Date: __________