GENERAL INTAKE FORMS

FIRST & LAST NAME:		**NICKNAME:**	
ADDRESS: **CITY:**		**STATE:**	**ZIP:**
CONTACT NUMBER:		**DRIVER LICENSE NUMBER (COPY IS REQUIRED UPON CHECK-IN)**	
EMAIL:		**OCCUPATION:**	
HEIGHT:	**CURRENT WEIGHT:**	**GOAL WEIGHT:**	**BP If Known:**
BIRTH DATE:	**AGE:**		
EMERGENCY CONTACT:		**CONTACT #:**	**RELATIONSHIP:**
MARITAL STATUS:	Single Married Divorced Widowed Domestic Partnership		
PRIMARY PHYSICIAN: **DATE OF LAST VISIT:**			
LIST ANY MAJOR HOSPITALIZATIONS, OPERATIONS OR ILLNESS:			

LIST YOUR PRIMARY SYMPTOMS OF CONCERN YOU WANT TO ADDRESS BY PRIORITY

SYMPTOM/CONCERN	DATE OF ONSET	FREQUENCY	SEVERITY
Example: Headaches	*June 2014*	*4 x weekly*	*Mild, Moderate or Severe*

IMPORTANT – PLEASE READ CAREFULLY BEFORE SIGNING: I certify that the information provided is true and correct and that I am a competent adult of at least 18 years of age, or that I am a minor, under the age of 18, I understand that the consent of my parent/guardian/person having legal custody will be required before treatment. FURTHER, I UNDERSTAND A COMPLIMENTARY CONSULTATION IS PROVIDED BY THE PHYSICIAN'S APPOINTED NON-MEDICAL REPRESENTATIVE AND IS STRICTLY TO PROVIDE PROGRAM/TREATMENT INFORMATION

FAMILY HISTORY INFORMATION – CHECK ALL THAT APPLY

CHILD	SIBLINGS	FATHER	MOTHER	SELF	DISEASES / DISORDERS	PHYSICIAN NOTES
					ABNORMAL BLOOD PRESSURE	
					ARTHRITIS OR JOINT PROBLEMS	
					ASTHMA, BRONCHITIS	
					AUTOIMMUNE DISEASE	
					BLOOD DISORDERS/ANEMIA	
					CANCER/TUMORS/CYSTS	
					COLITIS	
					CROHN'S DISEASE	
					DEPRESSION/MENTAL ILLNESS	
					DIABETES	
					ECZEMA/PSORIASIS	
					ENDOCRINE DISORDER	
					EPILEPSY	
					EXCESSIVE BLEEDING	
					GALL STONES	
					HEART DISEASE	
					HERPES/COLD SORES	
					HIGH CHOLESTEROL/LIPIDS	
					HIV	
					HEPATITIS	
					HPV/HUMAN PAPILLOMAVIRUS	
					JAUNDICE/LIVER DISEASE	
					KELOID SCARRING	
					KIDNEY INFECTIONS/STONES	
					EMPHYSEMA	
					MELANOMA/SKIN CANCER	
					PARASITES	
					PHLEBITIS/VARICOSE VEINS	
					PNEUMONIA	
					REOCCURRING INFECTIONS	
					RHEUMATIC FEVER	
					RHEUMATOID ARTHRITIS	
					THYROID DISEASE	
					TUBERCULOSIS	
					SEIZURES	
					STROKE	
					ULCERS	

LIST CURRENT RX MEDICINES & USED IN THE PAST 6 MONTHS

CHECK ALL THAT APPLY

BLOATING, GAS, FLATULENCE	HAIR LOSS - FALLING OUT	SENSITIVE TO COLD
HEARTBURN, REFLUX	DRY HAIR	PALPITATIONS/FLUTTERS
CONSTIPATION	THINNING HAIR	DIFFICULTY GETTING TO SLEEP
HEMORRHOIDS	NAUSEA/VOMITING	INSOMNIA
BOWEL HABIT CHANGES	EARS RINGING/DIZZINESS	PSORIASIS/ACNE FLAREUPS
COUGHING/WHEEZING	FATIGUE	DRY SKIN

Revive

FOOD ALLERGIES/INTOLERANCES	TIRED UPON WAKING	URINARY TRACT INFECTIONS
SEASONAL ALLERGIES/HAY FEVER	FRONTAL HEADACHES/SINUSITIS	ARTHRITIS/JOINT ACHES & PAINS
CRAVINGS - SWEETS	COLD HANDS/FEET	LOWER BACK PAIN/STIFFNESS
CRAVINGS - SALT	POOR CIRCULATION	DEPRESSION, WEEPINESS
CRAVINGS – BEER, WINE, LIQUOR	PUFFY FACE, SWOLLEN EYELIDS IN MORNING	ANXIETY, IRRITABILITY, TEMPER

Patient Name: _____

Patient Signature: _____

Date: _____

Therapy Management Agreement

This agreement between _____ ("Patient") and Revive IV Hydration lounge (RL) establishes guidelines and conditions for the use of IV Vitamin and Hydration Therapy. RL and patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient/practitioner relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and, therefore, these agents are prescribed with caution. The patient agrees and accepts to the following conditions:

1. I understand that the Vitamins I am receiving for me based on diagnoses derived from my submitted medical history, and the results of lab work (If needed) and a physical examination. The medications are to be used exclusively for treatment of medical conditions in accordance with applicable state and Federal law.

2. I certify that the answers I provided to the health questions on the Health History laboratories are accurate and correct to the best of my knowledge and that I have not been coached by any third party nor have I knowingly been deceptive for secondary gain, for medical treatment or prescription of a medication.

3. I do not have any history of Diabetes, Congestive heart failure or any other type of heart disease.

4. I have discussed and understand the risks and benefits associated with IV hydration therapy. I will immediately report any adverse side effect related to my treatment to Revive IV Hydration Lounge and discontinue use until advised to resume usage by my health care provider. I voluntarily assume any and all possible risks which may be associated with IV Hydration Therapy.

5. I understand that representatives of Revive IV Hydration Lounge and/or Licensed Physicians Assistant are available for questions and/or concerning during normal business hours throughout the course of my treatment.

6. I understand that IV Hydration Therapy is not covered by health insurance. I agree that all services and medications provided by Revive IV Hydration Lounge or its associated providers are to be paid for in advance. I will not seek reimbursement through my health insurance company, Medicare, Medicaid, or other third party payer.

7. I agree that the Revive IV hydration Lounge/physician relationship is not intended to replace the existing patient/physician relationship with my current primary care provider (PCP) and the treatment provided by Revive IV Hydration Lounge will be in conjunction with the care provided by my current PCP.

8. I agree that I will use my medication at the prescribed rate and dosage and will keep the medication in its respective labeled container.

I have read and agree to the terms of this the Therapy Management Agreement.

Patient Name: _____

Patient signature: _____

Date: _____