FORTIFY IV
NUTRIENT INJECTIONS & INFUSIONS

GENERAL INFORMATION

Date: _____ How did you hear about us? _____

First Name _____ Last Name _____

DOB _____ Age _____ Gender: Male Female

Address _____

City/State/Zip Code_____

Phone (Cell) _____ (Home)_____ (Work)_____

Email _____

Emergency Contact Name _____.

Emergency Contact Phone _____.

What are your goals with nutrient infusion/injection therapy?

1)_____ 2)_____

3) _____ 4)_____

GENERAL HEALTH

Are you currently being treated by a physician for ANY reason? YES NO

If YES, please explain _____.

Do you have any health problems? YES NO

If YES, please list _____.

_____.

Do you have any allergies or sensitivities? Sulfur allergy? YES NO

If YES, please list _____.

_____.

Do you smoke? YES NO If YES, how much/often? _____

Do you drink alcohol? YES NO If YES, how much/often? _____

Do you exercise? YES NO If yes, how often/type? _____

MEDICAL HISTORY

Circle appropriate answer: **YES**- *a condition you currently have*, **PAST**- *a condition you've had in the past*

Gastrointestinal			**Musculoskeletal**		
Irritable Bowel Syndrome	YES	PAST	Osteoarthritis	YES	PAST
GERD (reflux)	YES	PAST	Fibromyalgia	YES	PAST
Crohn's/Ulcerative Colitis	YES	PAST	Rheumatoid Arthritis	YES	PAST
Peptic Ulcer Disease	YES	PAST	Chronic Pain	YES	PAST
Celiac Disease	YES	PAST	Other:	YES	PAST
Gallstones	YES	PAST	**Skin**		
Other:	YES	PAST	Eczema	YES	PAST
Respiratory			Psoriasis	YES	PAST
Bronchitis	YES	PAST	Acne	YES	PAST
Asthma	YES	PAST	Other:	YES	PAST
Emphysema	YES	PAST	**Cardiovascular**		
Pneumonia	YES	PAST	Angina	YES	PAST
Sinusitis	YES	PAST	Heart Attack	YES	PAST
Sleep Apnea	YES	PAST	Heart Failure	YES	PAST
Other:	YES	PAST	Hypertension	YES	PAST
Urinary/Genital			Stroke	YES	PAST
Kidney Stones	YES	PAST	High Cholesterol/Triglycerides	YES	PAST
Gout	YES	PAST	Rheumatic Fever	YES	PAST
Interstitial Cystitis	YES	PAST	Arrhythmia (irregular heartbeat)	YES	PAST
Recurrent Yeast Infection	YES	PAST	Murmur	YES	PAST
Recurrent Bladder Infection	YES	PAST	Mitral Valve Prolapse	YES	PAST
Sexual Dysfunction	YES	PAST	Valve Repair/Replacement	YES	PAST
Sexually Transmitted Disease	YES	PAST	By-pass Surgery/Stents	YES	PAST
Other:	YES	PAST	Other:	YES	PAST

Endocrine/Metabolic			Hepatitis	YES	PAST
Diabetes	YES	PAST	Other:	YES	PAST
Hypothyroidism	YES	PAST	**Neurological/Emotional**		
Hyperthyroidism	YES	PAST	Seizure Disorder	YES	PAST
Polycystic Ovary Syndrome	YES	PAST	ADD/ADHD	YES	PAST
Infertility	YES	PAST	Headaches	YES	PAST
Insulin Resistance	YES	PAST	Migraines	YES	PAST
Eating Disorder	YES	PAST	Depression	YES	PAST
Hypoglycemia	YES	PAST	Anxiety	YES	PAST
Other:	YES	PAST	Autism	YES	PAST
Inflammatory/Autoimmune			Multiple Sclerosis	YES	PAST
Rheumatoid Arthritis	YES	PAST	Parkinson's Disease	YES	PAST
Chronic Fatigue Syndrome	YES	PAST	Dementia	YES	PAST
Food Allergies/Sensitivities	YES	PAST	Other:	YES	PAST
Environmental Allergies	YES	PAST	**Cancer**	YES	PAST
Multiple Chemical Sensitivities	YES	PAST	Lung	YES	PAST
Autoimmune Disease	YES	PAST	Breast	YES	PAST
Immune Deficiency	YES	PAST	Colon	YES	PAST
Mononucleosis	YES	PAST	Skin	YES	PAST
			Other:	YES	PAST

Have you ever had IV or injectable vitamin therapy? YES NO

If YES, when and what type of therapy _____.

Have you had prolonged or regular use of NSAIDS (Ibuprofen, Aleve, Motrin, etc.) or Aspirin? YES NO

Have you had prolonged or regular use of Tylenol? YES NO

MEDICATIONS & SUPPLEMENTS

Please list ALL current prescription medications, over the counter medications, vitamins, and supplements you take on a regular basis.

Medication/Vitamin/Supplement	Dosage/Frequency

DIAGNOSTIC STUDIES

Please indicate if you have had any of the following diagnostic studies and provide the approximate date these tests were performed.

Diagnostic Study	**Date**
Comprehensive Blood Testing (cholesterol, glucose, chemistry, etc.)	
Vitamin D level	
Vitamin B12 level	
Food Sensitivity Testing/Environmental Allergy Testing	
Hormone/Neurotransmitter/Organic Acid Testing (DUTCH test, Saliva test)	
Comprehensive Stool Analysis	
Micronutrient Panel	
Genetic Testing (23 & me)	
Hair Analysis/ Heavy Metal Testing	
Other:	

NUTRITION

Please tell us about your dietary habits.

Do you feel you have healthy eating habits? YES NO

Do you currently follow any of the following diets or nutrition programs? Circle all that may apply.

Vegetarian Vegan Allergy/Elimination Low Fat Paleo Low Carb/Keto

High Protein Blood Type Low Sodium Dairy Free Gluten Free Intermittent Fasting

Other: _____

How many meals do you eat per day, including snacks? _____

Do you consume caffeine? YES NO How often/how much? _____

Do you drink water? YES NO How many glasses per day? _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concerns. I understand that failure to disclose an accurate health history could result in potential adverse effects from the services I wish to receive.

_____.

Client Signature **Date**