Intake Questionnaire

(Zola Vitality Spa LLC)

Date: _____

Name: _____ DOB: _____ Age: _____

Address: _____

_____

Phone: _____ Email: _____

Reason for visit: _____

Emergency Contact: _____

Please briefly describe why you are seeking IV infusion or injection therapy? For example: Are you looking to improve your energy, skin/hair/nail quality, recovery times, immune system, or hydration status? Are you seeking treatment for a hangover or looking to feel and look better?

_____
_____
_____
_____

Allergies (Medications, foods, etc.):

_____
_____

Current Medications: (Please include OTC & supplements)

_____
_____
_____

Intake Questionnaire

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Please check any conditions that apply to you:

CARDIOVASCULAR AND RESPIRATORY

- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Valve Disorder
- ☐ Abnormal Rhythm
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Cardiac Surgery or Stents
- ☐ Congestive Heart Failure
- ☐ Peripheral Artery Disease
- ☐ Thrombosis or DVT
- ☐ Aneurysm
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Pulmonary Hypertension
- ☐ Lung Cancer
- ☐ Other Lung Disorder _____
- ☐ 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
- ☐ Rheumatoid Arthritis
- ☐ Hx of DKA
- ☐ Other _____

NEUROLOGIC

- ☐ Stroke/TIA
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ Multiple Sclerosis
- ☐ Seizures – date of last seizure _____

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_____

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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 drunk 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 like is important?

_____

_____

_____

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

Signature: _____ Date: _____

Print name: _____