INJECTION CLINIC INTAKE & QUESTIONNAIRE

Today's Date: _____/_____/_____
Month Day Year

PATIENT INFORMATION

Name: *(First)* _____ *(Middle Initial)* ___ *(Last)* _____

Preferred Name: _____ Date of Birth: _____/_____/_____

Address:_____ Apartment/Unit/Suite #: _____

City: _____ State: _____ Zip Code: _____-_____

Gender: ☐ Male ☐ Female E-mail: _____

Other name(s) that records may be kept under: _____

Primary Phone # ☐ Home ☐ Work ☐ Cell (_____) _____
Confidential voicemails OK? ☐ No ☐ Yes

Secondary Phone # ☐ Home ☐ Work ☐ Cell (_____) _____
Confidential voicemails OK? ☐ No ☐ Yes

Are you currently employed? ☐ No ☐ Yes Employer: _____

Who is your primary care provider? _____

Have you seen a Naturopathic Doctor before? ☐ No ☐ Yes
If yes, please provide name if different than your primary care: _____

EMERGENCY CONTACT

In case of an emergency, please contact:

Name: _____ Relationship: _____

Primary Phone: (___) ___-_____ Secondary Phone: (___) ___-_____

TERMS AND CONDITIONS

Please read carefully and initial:

1. **Informed Consent for Treatment:**
   a. I voluntarily consent to the vitamin/nutrient injections offered at the Medical Center at PRO Sports Club, realizing I am free to withdraw my consent and discontinue participation in these procedures at any time.
   b. The Injection Clinic reserves the right to refuse services to anyone deemed unfit to receive vitamin/nutrient injections based on the provider's decision making.
   c. I understand that vitamin/nutrient injections may not be approved by the United States Food and Drug Administration for the treatment of my medical condition or symptoms.

d. I understand the following may occur: pain, discomfort, muscle soreness, redness, bruising, and/or swelling at the injection site. This should be mild and start to get better within 48 hours. In rare cases: allergic reaction, fainting, nausea, diarrhea, itching, hives, headache, dry mouth, difficulty sleeping, blurred vision, unpleasant taste, increased urination, cramps, and/or metabolic disturbances may occur. ***(Initials: _____)***

2. **Self-Pay:**
   a. I understand that this appointment will not be billed to insurance and that I will pay the specific injection price at the time of service.
   b. Although vitamin/nutrient therapy may be medically beneficial, insurance will not reimburse the service since the injection is not medically necessary. I understand that the injections offered at The Medical Center at PRO Sports Club are non-reimbursable, as they are looked upon as vitamin supplementation to insurance companies. I agree I will not submit a claim or request The Medical Center or their staff to submit a claim for the Injection Clinic's services.
   c. These substances have not been evaluated by the Food and Drug Administration, therefore they are not intended to diagnose, treat, cure or prevent disease. ***(Initials: _____)***
3. **Cancellation Policy:**
   a. I understand that PRO Sports Club has a 24-hour cancellation policy and that a charge of $25 will be billed to me directly if I miss any appointment or fail to provide the required 24-hour notice when cancelling an appointment. I further understand that arriving late to a scheduled appointment may result in a shortened or rescheduled appointment. ***(Initials: _____)***

SIGNATURES

I certify that the information provided on this form is true and correct to the best of my knowledge. I give my permission for the practitioner to administer and perform such procedures as may be deemed necessary for treatment. By initialing above and signing below, I am indicating that I understand and agree to the above terms and conditions.

_____ _____/_____/_____

Patient – Age 18 or older *Month Day Year*

_____ _____/_____/_____

Parent/Guardian - If patient is under age 18 *Month Day Year*

INJECTION CLINIC INTAKE & QUESTIONNAIRE

Name: *(First)* _____ *(Middle Initial)* ___ *(Last)* _____

Preferred Name: _____ Date of Birth: _____/_____/_____

PATIENT QUESTIONNAIRE

In order to obtain an injection, please answer the following questions to the best of your knowledge:

What are your main health concerns and/or health goals? _____

_____

_____

Do you have any medication allergies or any allergic reactions to anything else? ☐ No ☐ Yes
If yes, please explain _____

_____

Have you ever had any problems with shots/injections in the past? ☐ No ☐ Yes
If yes, please explain _____

_____

Please list all medications and supplements you are taking including prescriptions, over-the-counter medications, vitamins, minerals, herbs, and homeopathic remedies: Check here if none ☐

_____

_____

_____

SOCIAL HISTORY INTAKE

Do you consume alcohol? ☐ No ☐ Yes If yes, how many drinks per week:_____

Do you use tobacco? ☐ No ☐ Yes If yes, please provide amount/packs per day: _____

Do you use cannabis? ☐ No ☐ Yes How often? _____ In what forms?_____

My energy level typically runs around (1=lowest, 10=highest): _____

My stress level typically runs around (1=lowest, 10=highest): _____

HEALTH QUESTIONNAIRE

Please check all that apply:

Do you struggle with:

☐ Low energy/fatigue
☐ Swollen/sore tongue
☐ Tingling/numbness in hands/ feet
☐ Memory loss, dementia, or Alzheimer's Disease
☐ Poor focus and/or brain fog
☐ Infertility
☐ Low mood/depression
☐ Irritability
☐ Skin unusually pale
☐ Skin inside mouth unusually pale
☐ Poor sleep quality and/or length
☐ Experience dizziness/ lightheadedness
☐ Brittle nails/hair
☐ IBS, Crohn's/Celiac disease
☐ Indigestion, gas, bloating, or other GI issues
☐ Cold hands/feet
☐ Difficulty walking
☐ Shortness of breath with minimal exertion
☐ Frequent headaches
☐ Easy bruising
☐ Frequently sick
☐ Diabetes

Health questionnaire continued…

- ☐ History of blood clots
- ☐ Frequent poor diet choices
- ☐ High stress levels
- ☐ Weight gain and/or inability to lose weight
- ☐ Unexplained weight loss
- ☐ PMS or other hormonal imbalance
- ☐ Anxiety
- ☐ Anemia
- ☐ Liver disease
- ☐ High levels of homocysteine in blood
- ☐ Poor recovery/healing following exercise, illness, or wounds
- ☐ NONE OF THE ABOVE

Do you have?

- ☐ Sulfa Allergy (a small possibility of cross-reaction with Metabolic Shot and Immune Boost injections only)
- ☐ Hemophilia or other bleeding disorder
- ☐ Kidney Disease
- ☐ Cancer or being treated for cancer
- ☐ Sensitivity to benzyl alcohol, cobalt and/or cobalamin
- ☐ HIV or immunosuppression
- ☐ Diagnosed having Leber's Disease
- ☐ Severe fear or fainting with needles
- ☐ NONE OF THE ABOVE

Are you?

- ☐ Pregnant/Nursing
- ☐ Taking an anti-seizure medication
- ☐ Under 18 years of age
- ☐ Taking antibiotic Trimethoprim or Bactrim
- ☐ Taking Fluorouracil or Methotrexate
- ☐ A vegan or vegetarian
- ☐ On acid blocking medication/PPI
- ☐ An athlete or exercise frequently
- ☐ Diagnosed with neuropathy
- ☐ On a detox
- ☐ Diagnosed with pernicious anemia
- ☐ Positive for MTHFR genetic polymorphism
- ☐ 50 years or older
- ☐ NONE OF THE ABOVE

SIGNATURES

_____ _____/_____/_____

Patient – Age 18 or older *Month* *Day* *Year*

_____ _____/_____/_____

Parent/Guardian - If patient is under age 18 *Month* *Day* *Year*