

Please email your completed form to our nurse Neva, veeprice@holyriverhealth.com or bring it to your nurse consult. If you have questions you can email her or call our office at 601.738.5075.



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Personal Wellness Profile

CONCIERGE IV INFUSION THERAPY

Getting to Know You

Name _____ Sex: M / F DOB ____/____/____ Age ____

Home Address _____

Cell Phone _____ Email _____

Check Marital Status: Single Married Separated Divorced Widowed Other

Check Work Status: Employed Unemployed Retired Disabled At-home Parent Other

Occupation _____ Workplace _____

Emergency Contact

Name _____ Relationship _____

Address _____ Phone _____

Yes, I authorize this person to receive medical information on my behalf in an emergency.

Primary Care Physician

Do you currently have a Primary Care Physician? Y / N Dr.'s Name _____

Have you had labs drawn within the last 3 months? Y / N Lab/Office Name _____

Would you like us to follow up with you for primary care? Y / N Select any desired services below:

- Yearly Physical Chronic Disease Care EKGs/Labs Mental Health GLP-1 Support
 Illness/Injury Medicare Wellness Sports Physical Telehealth _____



Personal Health History

For the following sections, please answer honestly and accurately. Please check **YES** beside any of the following conditions you've been diagnosed with or treated for. Leave blank if **NO** or **NOT APPLICABLE**.

YES	Do you have any history of heart, liver, or kidney failure?	YES	RESPIRATORY
	Are you currently pregnant, trying, or breastfeeding?		Asthma
	Do you have a known G6PD deficiency?		COPD / Emphysema
			Seasonal Allergies (Allergic Rhinitis)
	CARDIOVASCULAR & CIRCULATORY		INFECTIOUS DISEASE
	Atrial Fibrillation (AFIB) or Other Heart Arrhythmias		Hepatitis B or Hepatitis C
	Congestive Heart Failure (CHF)		HIV (Human Immunodeficiency Virus)
	Coronary Artery Disease		Malaria, Ebola, or Tuberculosis
	Hyperlipidemia (High Cholesterol)		Syphilis or other STDs/STIs
	Hypertension (High Blood Pressure)		
	Stroke or TIA (Mini-stroke)		NEUROLOGICAL & MENTAL HEALTH
			ADHD
	HEMATOLOGIC (BLOOD & COAGULATION)		Anxiety / Depression
	Anemia (Iron Deficiency)		Migraines / Chronic Headaches
	Blood Disorders / Hemophilia / Sickle Cell Anemia		Substance Use Disorder (Tobacco, Alcohol, Drugs)
	Edema (Unexplained Swelling)		
	Hemachromatosis (High Iron Levels)		GASTROINTESTINAL, RENAL & HEPATIC
			Chronic Kidney Disease (CKD)
	METABOLIC, ENDOCRINE & NUTRITIONAL		GERD / Acid Reflux / Kidney Stones
	Diabetes (Type 1 or 2)		Liver Disease or Cirrhosis
	Electrolyte Imbalances (e.g., Low Potassium/Magnesium)		
	Hypercalcemia (High Calcium in Blood)		MUSCULOSKELETAL & IMMUNE
	Hypermagnesemia (High Magnesium Levels in Blood)		Arthritis (Osteo or Rheumatoid)
	Hypokalemia (Low Potassium Levels)		Autoimmune Disorders of Any Type
	Obesity (Elevated BMI)		Cancer of Any Type
	Thyroid Disorders (Hypothyroidism or Hyperthyroidism)		Chronic Back or Neck Pain
	Vitamin B12 Deficiency		Latex, Adhesive, Vitamin, or Mineral Allergies
	Vitamin D Deficiency		

Other Conditions or Comments: _____



Personal Health History Continued

For the following section, please answer honestly and accurately. Please check YES beside any of the following conditions you've been diagnosed with. Leave blank if NO or NOT APPLICABLE.

YES

- Are you taking or have recently taken Digoxin (Lanoxing), Coumadin (Warfarin) or other blood thinners? _____
- Are you taking or have recently taken antibiotics like Ceftriaxone? _____
- Are you taking or have recently taken Diuretics or water pills? _____
- Is your blood pressure currently elevated? _____
- Are you currently running a fever or being treated for a systemic infection? _____
- Are you currently dehydrated for any reason? Describe: _____
- Are you a smoker? How long have you been smoking? _____
- Do you drink alcohol? How many alcoholic drinks do you consume per week? ___1 ___2 ___3 ___4+
- Do you use any recreational drugs? If yes, which ones and how often? _____
- Has your doctor placed you on a restricted-fluid or low-sodium diet? Describe: _____
- Do you have a healthy diet? Please list any dietary concerns: _____
- Do you exercise regularly? How many times per week? ___1 ___2 ___3 ___4 ___5+
- Have you ever had a reaction from an IV infusion? _____
- Have you ever passed out from the sight of blood or needles? _____
- Have you ever had a reaction from taking vitamins or supplements? _____

Please list any additional conditions, surgeries, food/drug allergies or sensitivities not yet mentioned:

Please list all prescriptions, OTC medications, and any vitamins and/or supplements you currently take:

Medication/Supplement	Strength	Frequency



Toxin Exposure & History

Do any of these significantly affect you / Do you have heavy exposure to these? Check all that apply.

BIOLOGICAL	CHEMICAL		ENVIRONMENTAL/PHYSICAL	
<input type="checkbox"/> Dust Mites	<input type="checkbox"/> Cigarette Smoke	<input type="checkbox"/> Industrial Chemicals	<input type="checkbox"/> Air Travel	<input type="checkbox"/> Smoke/Fire Exposure
<input type="checkbox"/> Farm Animals	<input type="checkbox"/> Cleaning Chemicals	<input type="checkbox"/> Old Paint/Paint Fumes	<input type="checkbox"/> Auto/Machine Exhaust	<input type="checkbox"/> Stuffy/Stagnant Air
<input type="checkbox"/> Mildew	<input type="checkbox"/> Contact with Smokers	<input type="checkbox"/> Perfume/Scents	<input type="checkbox"/> Carpets/Rugs	<input type="checkbox"/> Water Leaks
<input type="checkbox"/> Mold	<input type="checkbox"/> Gas Stoves	<input type="checkbox"/> Salon/Aesthetic Chemicals	<input type="checkbox"/> Damp Environments	<input type="checkbox"/> Wildfire Exposure
<input type="checkbox"/> Pets/Dander	<input type="checkbox"/> Heavy Metals	<input type="checkbox"/> Secondhand Smoke	<input type="checkbox"/> EMF/EMR	
<input type="checkbox"/> Pollen	<input type="checkbox"/> Herbicides/Pesticides	<input type="checkbox"/> VOCs	<input type="checkbox"/> Renovations	

Current Health Issues

Please check any and all conditions which apply to you today.

MENTAL	PHYSICAL		METABOLIC/DIGESTIVE	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Allergies/Asthma	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> GI/Digestive Issues	<input type="checkbox"/> Slow Metabolism
<input type="checkbox"/> Brain Fog	<input type="checkbox"/> Balance/Dizziness	<input type="checkbox"/> Low Energy/Fatigue	<input type="checkbox"/> Malabsorption Issues	<input type="checkbox"/> Unexplained Weight Gain
<input type="checkbox"/> Depression	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Muscle Injury/Pain	<input type="checkbox"/> Metabolism Issues	<input type="checkbox"/> Unexplained Weight Loss
<input type="checkbox"/> High Stress	<input type="checkbox"/> Cold/Flu Symptoms	<input type="checkbox"/> Post-Surgical Healing	<input type="checkbox"/> Menstrual Pain	
<input type="checkbox"/> Irritability	<input type="checkbox"/> Dull/Dry Skin	<input type="checkbox"/> Recovering from Illness	<input type="checkbox"/> Nausea	
<input type="checkbox"/> Low Mood	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Shakiness/Tremors	<input type="checkbox"/> Poor Diet/Busy Lifestyle	

Acknowledgement & Consent

To set clear expectations and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ I understand that some health conditions may be prohibitive to receiving IV Infusion Therapy and these decisions are made by the provider with my health and safety foremost in mind. To the best of my ability, the information I have supplied is complete and truthful.

_____ I understand that risks include, but are not limited to, local irritation, bruising, infection, phlebitis (vein inflammation), and in extremely rare cases, allergic reaction or fluid overload.

_____ I instruct the provider to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health and that individual results will vary.

_____ I understand that most IV Infusions and related treatments/services are cash-pay only and that I am responsible for the payment of any services I receive.

Patient Signature _____ Date ____/____/____