Name: ____________________________________ DOB:_________________ Age: _______

Address:____ Gender: M / F

City, State, Zip: ____

Cell phone: ___________________________________ Other phone: ___________________________

Ok to Text: Y / N Email: _________________________________

Emergency Contact: ____________________________ Phone: ________________________________

How did you hear about Revive?

____
____
____

Have you had IV vitamins before? If yes, what type and how long ago?

____

Have you ever had any problems/reactions from IV vitamins?

____

Do you have any allergies to food or medication? (List here):

____
____

Additionally, do you have allergies to any of the following?

Sulfur __ yes __ no Lidocaine/procaine __ yes __ no Fava beans __ yes __ no

Latex __ yes __ no Shellfish __ yes __ no Iodine __ yes __ no

Have you ever tested positive for G6PD deficiency? __ yes __ no

Are you taking any prescription or non-prescription medication? (Include vitamins/herbal supplements):

____
____
____

Please tell us the main reason you seek treatment today:

__ HYDRATION	__ HANGOVER	__ COLD/FLU REMEDY
__ JET LAG	__ IMMUNITY BOOST	__ CHRONIC FATIGUE
__ MIGRAINE	__ ATHLETIC PERFORMANCE	__ STRESS RELIEF
__ WEIGHT LOSS	__ TESTOSTERONE BOOST	__ DETOX
__ MENTAL FOCUS	__ ACUTE/CHRONIC PAIN	__ ANTI-AGING/SKIN HEALTH
__ MOOD ELEVATION	__ IMPROVE SLEEP	__ OTHER

Please tell us about your medical history:

__ Lupus or other auto-immune deficiency	__ History of kidney problems
__ Bleeding disorder	__ History of liver problems
__ Pregnant	__ History of Blood clot or pulmonary embolism
__ High blood pressure	__ History of heart or lung problems
__ Ankle swelling or generalized edema	__ Anxiety or panic attack

Do you smoke? __ yes __ no If yes, how much? ________________ For how many years? ___________

Do you drink alcohol? __ yes __ no If yes, how much? ____

Have you ever used illicit drugs? __ yes __ no If yes, what type? __________________________________

I certify the above medical and personal history is true and correct to the best of my knowledge. I am aware that it is my responsibility to inform the **Revive** provider of my current medical or health conditions and to update this history as it changes. A current medical history is essential for **Revive** to execute appropriate treatment.

Patient signature: ____ Date: ______________________

Provider Signature: ____ Date: ______________________