CAMERON WELLNESS CENTER

IV/B12 Injection Intake Form

Confidential Patient Information **Today's Date:_____**

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

How did you hear about us? _____

Were you referred by another physician or patient? ▢ Yes ▢ No

Name of referring patient/physician:_____

Emergency Contact: _____ Relationship: _____

Phone number: _____

Please mark which service you are interested in: ▢ B12 ▢ IV ▢ Both

What condition or symptoms are you hoping to treat with IV or B12 injection therapy?_____

Have you had IV or B12 injection therapy in the past? ▢ Yes ▢ No

Did you have any negative reactions or allergic reactions? ▢ Yes ▢ No ▢ Uncertain

Please describe any reaction:

_____

If you have had past IV please describe what was in it? _____

_____

Are you currently a Vegan or Vegetarian? ▢ Yes ▢ No If yes, for how long _____

Please list all supplements and medications you currently take: _____

_____

Have you ever fainted or become light headed from an IV, Injection, or having blood drawn?

▢ Yes ▢ No If yes please describe: _____

How often do you receive injection/IV therapies? _____

When was your last injection or IV therapy? _____

Please write a number between 1-10 (10 being worst), which describes your current state.

Fatigue: _____ Pain: _____ Stress: _____