NutrIV Therapies
Dr. Jason Pencek, FNP, DC

Functional Medicine Patient Intake & Health History Form

Thank you for coming. Please help us to provide you with a complete evaluation by taking the time to fill out this questionnaire. All your information will be confidential. If you have questions, please ask.

Contact Information *Today's Date:* _____/_____/_____

Name:_____ Sex: F___ M ___ DOB: _____/_____/_____ Age:____

Address: _____

Email Address: _____ Phone Number: _____

Occupation: _____ Emergency Contact:_____ Phone:_____

How did you find out about us? _____

What most interests you about our services? *(Please circle all that apply)*

Ozone *IV Therapy* *Peptides* *Hormones* *Prolo/Pain relief*

Have you ever or are you currently being treated by an alternative healthcare practitioner? Yes ___No ___

If so, who? _____ and for which conditions? _____

Have you ever received hormone therapy, IV therapy, peptide therapy or undergone medical weight loss programs? If so, when? _____What has been your experience? _____

Please list all medications and supplements you are currently taking: _____

Please list any known allergies (medications, food): _____

Please list any surgeries you have had in the past or will be undertaking: _____

Are you currently in pain? If so, please describe: _____

Please list your Typical Daily Diet

Breakfast: _____ Lunch:_____

Dinner_____ Snacks:_____

foods you struggle to limit or eliminate: _____

Do you currently smoke cigarettes or any other inhaled product? Yes ___No____ If you quit, date you stopped: _____

Do you drink alcohol? Yes ___ No___ If yes, how many drinks per week? _____

Do you use any recreational or mind-altering substances? Yes ___ No___

Major Health Complaint(s)

Please list your major health issues in order of significance to you and circle which you would like us to focus on today.

1._____ Date problem began: _____

Treatments tried: _____ What makes this problem better or worse: _____

2._____Date problem began:_____

Treatments tried: _____What makes this problem better or worse: _____

3. ._____ Date problem began: _____

Treatments tried: _____ What makes this problem better or worse: _____

4. ._____ Date problem began: _____

Treatments tried: _____ What makes this problem better or worse: _____

Please describe how these conditions affect or impair your daily activities? Examples may include your overall quality of life, work, family life, hobbies or self-esteem. _____

What is your ideal vision and goals for your health? _____

Is there anything else you would like us to know to support you reaching your ideal life?_____

Informed Consent for IV & Injection Therapies:

NutrIV Therapies provides IV and Injection therapies. You have the right to be informed of these procedures, any feasible alternative, and the risks and benefits. Except in emergencies, procedures are not performed until you have had an opportunity to receive such information and to give your informed consent.
The IV intravenous therapy involves inserting a needle into your vein and infusing over a determined period of time the prescribed nutrients (vitamins, minerals, amino acids). I understand that risks, benefits and alternatives to IVs may include but are not limited to: discomfort, bruising, and pain at the site of injection, as well as inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury. Severe reaction including anaphylaxis, cardiac arrest, or death are rare. The benefits of IV therapy are higher doses of nutrients received by the body than can be given orally and greater potential for the nutrients to infuse than oral route. Alternatives to IV therapy include lifestyle and dietary changes. I am aware that other unforeseeable complications could occur. I understand the risks and benefits of the procedure and have had the opportunity to have all my questions answered.

My signature below means that I have given my consent to IV and injection therapy, as recommended by the physician. I understand that there is no implied or stated guarantee of success or effectiveness of any treatment. The procedures set forth above have been adequately explained to me. I understand that I am free to withdraw my consent and to discontinue participation in these treatments at any time. I have received all the information and explanation I desire concerning the procedure and I authorize and consent to IV & Injection therapy.

Patient Name:_____ *Date:* _____

Patient Signature:_____

Be Optimal
HOLISTIC HEALTH CENTER
Becoming Your Best You

BE OPTIMAL OFFICE POLICIES

Communication is vital for good doctor patient relations. If you have any questions, comments, complaints or concerns, do not hesitate to bring them to our attention.

To maintain a peaceful atmosphere we ask that cell phones are silenced and all calls are taken outside.

Please check-in with the receptionist upon entering the office. Prior to your appointment please remove the contents of your pockets; jewelry, watches and other objects so they won't interfere with chiropractic adjustments.

If you've had a change in symptoms, become (or potentially become) pregnant or been involved in an accident (work, auto or otherwise) since your last visit, it is your obligation to report this to your doctor prior to your session.

Any questions you have regarding our policies are welcome at any time.

Payment Policy
Our office is not affiliated with HMO's, PPO's, or health insurance companies. Patients are charged directly for all services rendered by this office. Payment is due in full at time of service. We accept cash, check, Visa, MasterCard, American Express or Discover for payment. This office does not carry balances.

Health Insurance
It is not our policy, under any circumstances, to submit bills to your insurance company. If your insurance company covers chiropractic benefits, and you intend to submit bills, please let us know and we will be happy to provide you with a statement/claim at the time of checkout. A minimum charge of $10.00 per month will be applied for statements/claims that need to be reissued to you. If your insurance covers our services, you will be reimbursed directly. Should a check be mistakenly issued to Be Optimal or any of our practitioners from your insurance company, the check will be voided and sent to you (the patient). It will be your responsibility to contact your insurance company for reissuance. Additionally, you authorize our office to furnish any necessary information requested by your insurance company to process the claims you have submitted.

Nutritional Supplements & Products
Nutritional supplements, health supplies and any other products must be paid for at time of service.

Returned Checks
The fee for returned checks is $30.

Late Cancellation Fee
Patients are required to give **24 business hours advanced notice** when canceling any appointments. Please note, this is during regular business hours. For appointments scheduled on a Monday, Saturday or New Patient Initial Appointments, we do require **48 business hours advanced notice (5 days preferred)**. This allows the opportunity for someone else to schedule an appointment. Due to the doctor's full schedules and patients being turned away for appointments, if you are unable to give us the full advance notice you will be charged a late cancellation fee for **half of the visit price.**

Missed Appointments
You are fully responsible for canceling and/or rescheduling your appointment(s). An automatic reminder system is used as a courtesy to aid you in keeping track of appointments. Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "No-Show" and will be **charged the full amount** for their missed appointment.

Late Arrivals
If you happen to arrive late for an appointment, your visit will likely be shortened and end at the originally scheduled time in order to accommodate other patients whose appointments follow yours. Depending upon how late you arrive, your doctor will have to determine if there is enough time remaining to start your treatment. Regardless of the length of the treatment provided, you will be responsible for the **full amount** of your scheduled appointment

Opened Products & Product Returns

Any and all products sold at Be Optimal are considered purchased and are non-returnable if opened by the patient. Any product returns must be done within 30 days of purchase, in original condition and unopened, for store credit. Any special/custom orders (products not typically stocked at Be Optimal) are non-returnable.

Notice of Medical Procedures

I will notify a member of the front office staff or my practitioner of any recent medical procedures/hospitalizations (e.g. plastic surgery, botox, vaccines, implants, etc.) within 48 hours of any upcoming appointments.

I agree with the above Be Optimal Office Policies.
Initials _____

ADDITIONAL POLICIES/CONSENTS

Consent To Treat

I hereby consent to treatment as provided by the Physicians working at Be Optimal as determined by the Physician's diagnosis and professional judgment. If I do not agree to a course of treatment, I will raise concern and discuss it with the Physicians of Be Optimal prior to administration of the treatment. I also understand that other exams and tests such as x-rays, lab tests, etc. may be necessary to gain more information regarding my health.
Initials _____

Correspondence

We communicate with our patients through mail, e-mail, by text and over the phone. These communications include, but are not limited to birthday greetings, appointment reminders, missed appointment rescheduling and holiday cards. All appointment reminders are done as a courtesy through a text service. I hereby consent to receive communications on my home and/or cell phone, including leaving voice or text messages as well as through mail and email. We always do our best to honor your requests when communicating with you. If there is a way you DO NOT want us to communicate with you, please let the front office staff know.
Initials _____

Email List

I consent to receive emails related to marketing activities. These emails include our newsletters, updates, last minute openings & promotions. You have the ability to unsubscribe at any time.
☐ Yes ☐ No Initials _____

Sharing Information For Recommended Services

You agree to allow practitioners, including but not limited to Chiropractors, Nurses and Chinese Medicine Doctors to communicate with Be Optimal non-clinician based practitioners as to how they can best support your care. This is for services in which you are aware of the recommendation and have shown interest.
☐ Yes ☐ No Initials _____

Disclosure Of Information

Is there anyone you would like us to share your health information with during your course of treatment? ☐ Yes ☐ No
If yes, please provide, Name: _____Relationship: _____
Phone Number: _____

Privacy Notice

By signing, you acknowledge that you have had an opportunity to review our Notice of Privacy Practices and you understand and agree to the terms.

Patient Name: _____

Signature: _____ Date: _____