ARK INTEGRATIVE MEDICINE

Vitamin Infusion Welcome Packet

Ark Integrative Medicine welcomes you as a new vitamin-infusion patient to our medical clinic. We look forward to working with you as partners in your care.

Enclosed you will find several forms for your review prior to your appointment. Specifically, enclosed are the following:

- **Vitamin-Infusion General Information**
- **Patient's Electronic Communications Authorization and Consent Form**
- **Patient's Medical History Form**

At your appointment, you will also receive additional forms, including a Medical Informed Consent, and a copy of our office's privacy practices.

Please read and review the attached forms prior to your consultation, so that you are ready to ask questions about the process and your health.

Submitting Your Information

Once you have completed the following pages, you will have several options. You may **Save** the file to your desktop computer, from which you can email it back to Ark Integrative Medicine (email to: irvine@ark-imed.com); **Clear** all the form fields, should you need to redo any section; or use the **Print** button (which requires you to have access to a home or office printer) to print a hardcopy of the forms to bring to your appointment. You may also fax the completed forms to us, if you prefer.

If you forget to complete or submit these necessary forms prior to your appointment, you may be asked to fill them out again in our office before your consultation.

ARK INTEGRATIVE MEDICINE

Vitamin-Infusion General Information

What are Vitamins and Minerals?

Vitamins and minerals are essential substances that our bodies need to develop and function normally. The known vitamins include A, C, D, E, and K, and the B vitamins: thiamin (B1), riboflavin (B2), niacin (B3), pantothenic acid (B5), pyridoxal (B6), cobalamin (B12), biotin, and folate/folic acid. A number of minerals are also essential for optimal health: calcium, phosphorus, potassium, sodium, chloride, magnesium, iron, zinc, iodine, sulfur, cobalt, copper, fluoride, manganese, and selenium.

Multivitamins/multiminerals (MVMs) are the most frequently used dietary supplements, but MVMs cannot take the place of eating a variety of foods that are important to a healthy diet. However, some people who don't get enough vitamins and minerals from food alone, or who have certain medical conditions, might benefit from taking these vitamins and minerals in an IV form.

Do I Qualify for Vitamin Infusions?

From the outset, please know that only persons that pass our medical screening procedure are eligible to receive vitamin infusions. Certain medical conditions, including, but not limited to, high blood pressure, renal failure or congestive heart failure, may exclude you from eligibility because of the risk from receiving the fluids associated with the vitamin infusions.

For those that do qualify, infusions are effective because the delivery mechanism bypasses your gastrointestinal tract and introduces the vitamins and minerals directly into your bloodstream. As a result, your body rapidly rebalances its total fluids, helping to restore your energy and optimize your well-being.

If I Qualify, What Happens Next?

After Ark Integrative Medicine has determined that you are eligible to receive vitamin infusion therapy, you may begin the treatment.

How do I Pay for Vitamin Infusions?

Ark is not contracted with insurance companies, and does not file any claims for service. Therefore, payment is "out of pocket."

If you wish to pursue reimbursement from your insurers, Arkwill provide receipts for your service so that you may pursue any potential reimbursement. Ark does not investigate reimbursement policies by any health insurer.

Payment must be rendered prior to treatment, and may be made by cash, credit card, and HSA (health savings account). The cost of each vitamin infusion is listed on our website.

How Do I Get Started?

Please use our website to arrange your appointment, or call the office at the number below.

Next, please print out these forms and review them carefully. At the appointment, you and the treating physician will review your medical and psychiatric history to determine if you are eli-gible for treatment, review and discuss other important forms, such as the Patient's Informed Medical Consent, and discuss any questions you may have.

What Should I Expect?

The IVs used during the Intravenous (IV) infusion therapy are exactly the same that you would find in a hospital. Our infusions are given in a peaceful setting and should leave you feeling calm, relaxed, and refreshed. All of our infusions last from 45-240 min. Our experienced and attentive staff will keep you calm, cared for, and comfortable during your infusion. Patients find the experience tranquil and healing, and the goal is to leave feeling vibrant, energized, and refreshed.

Once your treatment is completed, the nursing staff will review with you the post vitamin infusion instructions and answer any further questions. You will also be provided a written copy of the discharge instructions at the end of your visit to help you remember how to optimize your vitamin infusion experience and maintain the health benefits and effects as long as possible.

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Ark Integrative Medicine 15785 Laguna Canyon Rd Ste. 125 Irvine, CA 92618
(949) 932-0350 Fax: (833) 594-2272 Email: irvine@ark-imed.com

VITAMIN INFUSIONS – WELCOME

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Does Ark Integrative Medicine Accept Emergencies?

No. If you are having an emergency of any type, call 911 and go to your nearest Emergency Department. Bloom Health does not provide Emergency Services. If you are having thoughts of suicide, please call the National Suicide Prevention Lifeline at 800-273-8255.

Does Ark Integrative Medicine Offer Prescriptions?

No. Ark does not provide prescriptions and does not provide refills on medica-tions from other physicians.

What is Ark Integrative Medicine's Termination Policy?

In some cases, it may be necessary to terminate the physician-patient relationship and forgo any further treatments by Ark Integrative Medicine. Termination may occur at any time and may be initiated by either the physician or the patient. Reasons for termination by the physician may include, but are not limited to, non-compliance with treatment, disrup-tion of facility operations, verbal or physical abuse of the staff, or any violation of the discharge instructions.

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Electronic Communications Authorization

I hereby authorize Ark Integrative Medicine ("Ark" hereinafter) to communicate with me using electronic communications including but not limited to email, text messages, voicemail, and video conferencing meetings. I authorize Ark to contact me solely by the telephone numbers, addresses, and information that I have provided to Ark during any part of our contact. These communications may include appointment information and reminders, protected health and confidential information. I understand that these electronic communications are not encrypted and that Ark is not responsible for the privacy of such communications once they have been transmitted to the numbers provided by me.

LAST NAME _____ FIRST NAME _____

TODAY'S DATE (MM/DD/YYYY) _____

☐ By selecting this check box, I consent to receive information from **Ark Integrative Medicine** through electronic correspondence.

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VITAMIN INFUSIONS – PATIENT HISTORY

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LAST NAME _____ FIRST _____ PREFERRED _____ D.O.B _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SEX: ☐ MALE ☐ FEMALE PHONE _____ EMAIL _____

EMERGENCY CONTACT NAME _____ EMERGENCY CONTACT PHONE _____

HOW DID YOU LEARN ABOUT **ARK INTEGRATIVE MEDICINE**:

☐ **Internet** ☐ **Facebook** ☐ **Friend/Relative** ☐ **Walk-in** ☐ **Other:** _____

WHAT ARE YOUR MAIN COMPLAINTS? (CHECK ALL THAT APPLY)

- ☐ **Fatigue or low energy**
- ☐ **Stress**
- ☐ **Poor diet/busy lifestyle**
- ☐ **Difficulty concentrating**
- ☐ **Low mood or depression**
- ☐ **Cold/Flu symptoms**
- ☐ **Facial wrinkles or fine lines**
- ☐ **Dull or dry skin**
- ☐ **Malabosorption issues**
- ☐ **Other:**

WHICH STATEMENTS BEST DESCRIBE WHY YOU ARE HERE TODAY? (CHECK ALL THAT APPLY)

- ☐ **I want to have more energy and feel better overall**
- ☐ **I want to do everything I can to nourish my body**
- ☐ **I want to do everything I can to enhance my weight loss efforts**
- ☐ **I want to learn about way I can improve longevity**
- ☐ **I want some education about healthy nutrition**
- ☐ **I want to prevent or treat dehydration**
- ☐ **I want to prevent getting sick**
- ☐ **I want to recover quickly from surgery or illness**
- ☐ **I want to look/feel younger**
- ☐ **I want to have smoother, brighter more vibrant skin**
- ☐ **I want to cleanse my body of toxins**
- ☐ **Other:** _____

YOUR PAST MEDICAL HISTORY INCLUDES: (CHECK ALL THAT APPLY)

- ☐ **Acid Reflux**
- ☐ **Alcohol/Drug Abuse**
- ☐ **Allergy Problems**
- ☐ **Anemia**
- ☐ **Artery/Vein Issues**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Autoimmune Disease**
- ☐ **Bleeding Problems**
- ☐ **Blood Clots**
- ☐ **Cancer** (Specify below)
- ☐ **Cataracts**
- ☐ **Chronic Pain**
- ☐ **Colitis/Crohns**
- ☐ **Depression, Anxiety**
- ☐ **Diabetes**
- ☐ **Esophagitis/Ulcers**
- ☐ **Fractures**
- ☐ **Gallstones**
- ☐ **Glaucoma**
- ☐ **Gout**
- ☐ **Headaches**
- ☐ **Heart Disease**
- ☐ **Heart Valve Issues**
- ☐ **Hernia**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **HIV/AIDS**
- ☐ **Irritable Bowel**
- ☐ **Kidney Disease**
- ☐ **Kidney Stones**
- ☐ **Liver Issues/Hepatitis**
- ☐ **Lung Disease**
- ☐ **Mental Health Issues**
- ☐ **Migraines**
- ☐ **MRSA**
- ☐ **Osteoporosis**
- ☐ **Skin Infections**
- ☐ **Recurrent UTI**
- ☐ **Seizures**
- ☐ **STDs**
- ☐ **Sleep Apnea**
- ☐ **Stroke**
- ☐ **Thyroid Diseases**
- ☐ **Tuberculosis (TB)**

☐ **Other diseases or ailments:** _____

☐ **Hospitalization/Serious injuries:** _____

Form Continues on Next Page

VITAMIN INFUSIONS – PATIENT HISTORY

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YOUR PAST SURGICAL PROCEDURE HISTORY: (CHECK ALL THAT APPLY)

- ☐ Angioplasty (Balloon)
- ☐ Appendix
- ☐ Arteries
- ☐ Bladder Suspension
- ☐ Blood Vessel Surgery
- ☐ Bypass
- ☐ Colon/Rectal Surgery
- ☐ Dental Surgery
- ☐ Eye Surgery
- ☐ Gallbladder
- ☐ Heart Surgery
- ☐ Heart Valve Surgery
- ☐ Hernia
- ☐ Hysterectomy, Complete
- ☐ Hysterectomy, Partial
- ☐ Orthopedic Surgery
- ☐ Kidney Surgery
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Prostate Surgery
- ☐ Sinus Surgery
- ☐ Stents
- ☐ Thyroidectomy
- ☐ Tonsils and/or Adenoids
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Veins

☐ **Other surgeries not listed above:**

☐ **Previous adverse reaction to anesthesia (please explain):**

MEDICATION LIST:

Please list all **prescription** and **non-prescription** medications you are currently taking including dosages. This may include vitamins, herbal medicine, supplements, birth control pills, inhalers, and over the counter medications.

DISCONTINUED MEDICATION LIST:

List all medications you have **stopped taking** in the last 12 months

ALLERGIES OR REACTIONS:

List all including allergies to medications, food, and environments

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FAMILY HISTORY OF DISEASE (CHECK ALL THAT APPLY)

- ☐ Addiction Problems
- ☐ Arthritis
- ☐ Bleeding Problems
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Prostate Cancer

Form Continues on Next Page

VITAMIN INFUSIONS – PATIENT HISTORY

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SOCIAL HISTORY:

WHICH BEST DESCRIBES YOUR CURRENT LIVING SITUATION? (CHECK ALL THAT APPLY)

☐ **Alone** ☐ **Spouse/Partner** ☐ **Child/Children** ☐ **Close Relative** ☐ **Other:** _____

WHOM DO YOU RELY ON FOR BASIC SUPPORT AND HELP? _____

CIGARETTE/NICOTINE USE:

☐ **Current Smoker** ☐ **Never Smoked** ☐ **Former Smoker** If former, when did you quit? _____ How many packs/day? _____

IF YOU SMOKE, ARE YOU INTERESTED IN QUITTING? **YES** ☐ **NO** ☐

OTHER NICOTINE USE? **YES** ☐ **NO** ☐ DO YOU USE A VAPING DEVICE? **YES** ☐ **NO** ☐

ARE YOU EXPOSED TO SECOND HAND SMOKE? **YES** ☐ **NO** ☐

ALCOHOL CONSUMPTION: (CHECK ALL THAT APPLY)

☐ **I don't drink alcohol** ☐ **I sometimes drink alcohol** ☐ **I frequently drink alcohol**

☐ **Beer** ☐ **Wine** ☐ **Liquor** How many drinks per week? _____

CAFFEINATED BEVERAGE CONSUMPTION: (CHECK ALL THAT APPLY)

☐ **I don't drink caffeine** ☐ **Coffee** ☐ **Tea** ☐ **Soda** ☐ **Energy Supplements** **How many drinks per week?** _____

RECREATIONAL DRUG USE:

☐ **YES** ☐ **NO** If yes, please list: _____

DO YOU EXERCISE REGULARLY:

☐ **YES** ☐ **NO** If yes, how many days per week? _____ Type of exercise: _____

HOW MANY HOURS OF SLEEP DO YOU GET PER NIGHT: _____ DO YOU WAKE IN THE MORNING FEELING RESTED: ☐ **YES** ☐ **NO**

FEMALE PATIENTS ONLY:

Date of your last menstrual period: _____ Have you gone through menopause? ☐ **YES** ☐ **NO**

Number of pregnancies: _____ Number of live births: _____ Current birth control method: _____

☐ By selecting this check box, I attest that the above personal health information is correct and complete to the best of my knowledge.

TODAY'S DATE: (MM/DD/YEAR) _____

SAVE CLEAR ALL PRINT