Welcome to The IV Lounge!

Thank you for taking the first step towards improving your health today!

We are excited to meet you on your unique journey and become the vessel in helping you achieve your personal health goals through intravenous hydration, supplementation, wellness programming, and anti-aging aesthetics.

By combining the information you provide with the bloodwork results we receive, we are confident that we will be able to design an effective, safe, personalized regimen that you can trust.

We understand everyone is different with various needs, which we are equipped to meet with our many combinations of.....

Let's set sail together by first helping us gather some general, but essential information about who you are.
We will get to the fun stuff soon!

First name *

Last name *

Email *

nikki@infinitelabsdigital.com

Phone number *

Street address

City

State

Next, we really want to understand what it is that makes you, well, YOU!

This is just the first step throughout this program where we will establish a personal connection with you to ensure that you achieve your desired outcome. Our passion is dedicated to helping you **age gracefully** and discover what your destination can look like.

As we embark on this journey with you, we are interested in learning what you have already tried, what brought you to us, and what you hope to accomplish.

We know, we have a lot of questions, and with your honest, detailed answers we will be able to accurately create your complete, customized, health goal stack that you are in search of. We are only here to help you at The IV Lounge, so don't worry about judgement.

What do you hope to achieve during your experience with The IV Lounge's personalized program?

If you had the ability to correct your top 5 complications, what would they be?

Complication #1

Complication #2

Complication #3

Complication #4

Complication #5

Alcohol (#/ Week)

Coffee (#/ Day)

Smoking (#/Day)

Soda (#/ Day)

Tea (#/ Day)

Water (# cups / Day)

Marijuana Usage

- ◯ Yes
- ◯ No

Sleep (Hours / Day)

Meals (# / Day)

Stress Level

Please Select

Energy Level

Please Select

Exercise (Hours / Week)

Age

Relaxation / Yoga / Meditation (# / Week)

What time do you eat:

Breakfast

Lunch

Dinner

What do you you normally eat for:

Breakfast Items

Lunch Items

Dinner Items

Snacking

Please explain when and what you snack on during the day

Have you ever had a nutrition consultation? How was your experience?

Have you made any changes in your eating habits due to health reasons?

Please explain what you changed and if you tried a specific program for weight loss / management.

How often do you weigh yourself?

- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Rarely
- ◯ Never

Current Weight

Desired Weight

Do you avoid any particular foods?

If yes, please explain what foods and reasons why.

What food item do you treat yourself to on occasion?

Who grocery shops for your house?

When you look at food labels, what section do you scan first?

Who cooks in your house?

How would you best describe your desired diet? Ex: Whole Food, Keto

Is this desired diet able to be achieved regularly?

What supplements do you take daily?

Please separate each with a comma or by returning

How many meals do you eat out per week?

- ◯ 0 - 1
- ◯ 1 - 3
- ◯ 3 - 5
- ◯ 5 <

Did something trigger you to make a change in your health?

What have you noticed that makes you feel worse, and how does this affect your body?

This can be food, mood, exercise, etc.

What have you noticed that makes you feel better, and how does this affect your body?

This can be food, mood, exercise, etc.

Please check any of the below that apply to you.

- ☐ Heart
- ☐ Kidney
- ☐ Lung
- ☐ Liver

- [ ] Cancer Recovery / Chemotherapy
- [ ] Nervous System
- [ ] Immune Support
- [ ] Asthma
- [ ] Auto Immune Disease
- [ ] Diabetes
- [ ] Pregnancy
- [ ] Allergies

I would like to add a dependent field here if they do check any of the above concerns, so they can type in detail if they would like to

Psychosocial Questions

Do you feel significantly less vital than you did a year ago?

- ◯ Yes
- ◯ No

Are you happy?

- ◯ Yes
- ◯ No

Do you feel your life has meaning and purpose?

- ◯ Yes
- ◯ No

Do you believe stress is presently reducing the quality of your life?

- ◯ Yes
- ◯ No

Do you like the work you do?

- ◯ Yes
- ◯ No

Do you have trouble falling asleep?

- ◯ Yes
- ◯ No

Do you feel rested upon awakening?

- ◯ Yes
- ◯ No

Do you have a known history of significant exposure to any harmful chemicals such as the following:

- [ ] Herbicides
- [ ] Insecticides (frequent visits of exterminator
- [ ] Pesticides
- [ ] Organic Solvents
- [ ] Heavy Metals
- [ ] Other

Additional Notes

Submit