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Patient Intake Form Pre-Ketamine Infusion

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Phone # for Private Calls: _____

Email: _____

Address: _____

Emergency Contact: _____

Referring Clinician Name and Phone: _____

Psychiatrist Name and Phone (if different from above):

_____

Principal Psychiatric Diagnosis: _____

How long have you had depression? _____

What other forms of depression treatment have you tried?

_____

What prompted you to seek IV ketamine infusion treatment?

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How did you hear about our IV ketamine infusion treatment?

Current medications (please include frequency and dose):

Allergies to medications: _____

Do you have a history of seizures or seizure disorder? Yes / No

Past medical history:

Past surgical history:

Have you ever had an adverse reaction to anesthesia? Yes / No
If yes, describe the event:

Substance abuse history:

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Tobacco: Yes / No

Alcohol: How many drinks per day and when was your last drink?

_____

Marijuana: Yes / No

Opiates: Yes / No

Cocaine: Yes / No

Any other recreational use of medications? Yes / No
If yes, please let us know what medication you are using and when was the last dose.

I certify that I have completed this questionnaire to the best of my knowledge.

Name: _____

Date: _____