

Do you use:	Amount
Coffee	
Cigarettes	
Alcohol	
Aspirin	
Cannabis	
Cocaine	
Other substance:	
Other substance:	

Supplement	Dosage

Please describe your digestion in detail. Any bloating, constipation, diarrhea, pain?

How is your appetite?

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT: By signing this document, I hereby authorize the staff of the Hahnemann Medical Clinic, Nancy Herrick PA, MA, DH (H) and Roger Morrison MD to treat me using Ketamine medicine. I understand and acknowledge the Hahnemann Medical Clinic staff will base their treatment decisions on community standards of Ketamine practice. If I desire to be treated according to conventional medication, I am free to seek such treatment from another physician. In some cases I may be encouraged or required to do so. I understand that Nancy Herrick and Roger Morrison act as specialists and not as primary care providers. I understand the Hahnemann Medical Clinic will make the best effort to treat me but makes no guarantees that their Ketamine treatment will cure me.

I understand that charges will be made and hereby agree that I am financially responsible for any such charges. I acknowledge that full payment is due at the time of my appointment and authorize my credit card to be processed at the end of my visit for the full amount due.

Signature _____ Date _____

Diseases Suffered From	Approximate Age	Duration	Whether you Completely Recovered	Medicines and Treatments Taken

Any extra remarks or information:

Mention any drugs, tonics, stimulants etc. that have been used by you at any time in life:

Information about Ketamine Therapy

We understand you are interested in the possibility of exploring Ketamine Therapy.

Ketamine can be effective for Sleeping disorders, Depression, even severe long term or treatment resistant Depression, Postpartum depression etc., Anxiety of all types, including ADHD and PTSD, Eating disorders of all types, Addictions including Opioid addictions or Alcohol, Smoking, Gambling or any Substance Abuse addictions etc., also Terminal illness, and Pain syndromes.

The first meeting is an hour long consultation.

At this meeting we will determine what type of Ketamine Therapy is most appropriate for you and answer any of your questions.

We offer the following choices:

Type A (and the most frequent choice for our patients) is a VERY LOW Dose taken daily at bedtime with a one month prescription from a pharmacy. There are almost no contraindications for this therapy and it tends to be very gentle and smooth without any side effects. This treatment plan can be set up to begin soon after an application form (that is quite extensive) is sent back, and your one hour appointment is completed. First dose of Ketamine may be prescribed at the end of this appointment. After three weeks, a 15 minute follow up appointment is needed to help determine the next step. It is important to have a 15 minute appointment monthly after that, as therapy is ongoing. This may be as brief as three months or longer depending on your outcome.

Type B is like a Traditional Ketamine Sojourn using higher dosages at 150 mg and providing an opportunity to explore deeper realms of your being.

This is a minimum 75 minute long appointment.

For this experience to be most effective it is required that you have been referred by your therapist or have had at least three sessions prior with a psychotherapist.

It is best to start with the low dose and move onto the Sojourn sometime later, we feel this may be the ideal arrangement.

There are some contraindications to using Ketamine. These are: Uncontrolled hypertension, Unstable heart disease, Diseases of the bladder, Active Psychosis, Active Mania, Current Substance abuse, including cocaine and finally Severe Dissociative disorder. If you have one of these conditions you most likely will be unable to use Ketamine but you can discuss this with a Ketamine Specialist Psychiatrist.

The Low dose method is fairly new and not much has been written about it yet.

The link below is of a letter from a patient treated with Low Dose Ketamine and her follow up.
<http://whale.to/b/kungurtsev.html>

If you are interested, please contact Lina, Office Manager of Hahnemann Medical Clinic at 510-412-9040 or email us at hmcrichmond@gmail.com .

Best Wishes for your Good Health,
Nancy Herrick PA, MA, DH (H)
Roger Morrison, M.D.

By signing below, I hereby acknowledge that I have completely read and fully understand the contents above and received a copy of the Hahnemann Clinic Ketamine Information Letter.

Signature

Date

Hahnemann Medical Clinic

Ketamine Controlled Medication Agreement

Appointments and refills of controlled medications:

___ I understand that controlled medications will be prescribed for use only during scheduled appointments.

___ I will make sure I have an appointment for requested refills.

___ If the medication is stolen, I will file a police report and provide a copy to my provider. I understand that the medication will not be refilled early.

Use of and storage of controlled medications:

___ These medications were prescribed to me by my provider after a thorough assessment of my medical history and symptoms, and so have not been deemed safe for anyone else to take.

___ I will not sell this medicine or share it with others. Such acts are illegal and can result in a felony charge.

___ I will keep the medicine secure and out of reach of children. I have been advised to obtain a lock box or other secure storage for medications.

___ I consent to my provider talking with my therapist and/or health care providers.

___ I will discuss all other medicines that I take or have been prescribed with my provider.

___ If for any reason I fill prescriptions at more than one pharmacy, I will communicate this to my provider.

___ I will not request any opioid pain medicines or other addictive medicines such as:

Benzodiazepines (Klonopin, Xanax, Valium) or stimulants (Ritalin, Amphetamines) without first talking with my provider. The only exception to this is if I need pain medicine for an emergency at night or on the weekends.

Treatment:

___ I am willing to be actively engaged in my health and wellness and to participate in the other forms of treatment listed in my treatment plan.

___ I agree to take my medication as prescribed. I understand that any deviation from the prescription could result in increased risks and/or running out of medication early. I will not change how I take the medication unless I discuss this first with my provider.

___ Due to the nature of controlled medications and the conditions they treat, abuse of alcohol or cannabis and/or use of illicit substances is contraindicated and can interfere with my treatment.

___ I understand that laboratory testing could be required periodically to continue treatment.

Signature _____

Date _____

Name _____

The Amino Acid Therapy Chart: The Neurotransmitter Restoration Process

Name _____

Date _____

Instructions:

- (1) In Column A, put a number from zero (no symptoms) to ten next to each symptom you feel, with one being slightly felt or hardly ever felt and ten being strongly felt or felt all the time.
- (2) Check the Column B substances that you use to reduce the symptoms in the same section of Column A.

Practitioner's Notes	Column A Neurotransmitter Deficiency Symptoms	Column B Substances Used	Column C Amino Acid Solutions*	Column D Neurotransmitter Promotes
	TYPE 1 Low Serotonin <input type="checkbox"/> negativity, depression <input type="checkbox"/> winter blues <input type="checkbox"/> worry, anxiety <input type="checkbox"/> low self-esteem <input type="checkbox"/> hyperactivity <input type="checkbox"/> obsessive thoughts or behaviors <input type="checkbox"/> perfectionist, controlling <input type="checkbox"/> irritability, rage <input type="checkbox"/> panic attacks <input type="checkbox"/> phobias (fear of heights, snakes, performing, small spaces, going out, etc.) <input type="checkbox"/> suicidal thoughts, intentions <input type="checkbox"/> fibromyalgia, TMJ, migraines <input type="checkbox"/> night owl, hard to get to sleep <input type="checkbox"/> insomnia, disturbed sleep <input type="checkbox"/> <i>afternoon or evening cravings for foods or other substances</i>	<input type="checkbox"/> sweets <input type="checkbox"/> starch <input type="checkbox"/> marijuana <input type="checkbox"/> alcohol <input type="checkbox"/> Ecstasy <input type="checkbox"/> Prozac <input type="checkbox"/> Zoloft <input type="checkbox"/> Effexor <input type="checkbox"/> Lexapro <input type="checkbox"/> Trazadone <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	5-HTP 50-200 mg as needed Tryptophan Either 500-2000 mg as needed. Use eves by 10:00 pm if sleep is a problem or symptoms persist into the evening Melatonin 1 - 6 mg for sleep before ideal bedtime; if the above does not work alone	Serotonin: positive outlook emotional flexibility self-confidence sense of humor Melatonin (made from Serotonin): 8 hours of deep restful sleep
	TYPE 2 Low Catecholamines <input type="checkbox"/> apathetic depression <input type="checkbox"/> lack of energy <input type="checkbox"/> lack of drive <input type="checkbox"/> lack of focus <input type="checkbox"/> bored, flat <input type="checkbox"/> ADD <input type="checkbox"/> <i>crave substances for energy or focus</i>	<input type="checkbox"/> caffeine <input type="checkbox"/> cocaine <input type="checkbox"/> meth <input type="checkbox"/> tobacco <input type="checkbox"/> Wellbutrin <input type="checkbox"/> Ritalin <input type="checkbox"/> Adderall <input type="checkbox"/> marijuana <input type="checkbox"/> chocolate <input type="checkbox"/> sweets	Tyrosine 500-2000 mg before 3:00 pm, as needed Phenylalanine same dosing for milder effects, fewer adverse reactions	Catecholamines: alertness energy focus drive enthusiasm elation
	TYPE 3 Low GABA <input type="checkbox"/> stiff, tense, or painful muscles <input type="checkbox"/> stressed /burned out <input type="checkbox"/> unable to relax/loosen up/get to sleep <input type="checkbox"/> often feel overwhelmed <input type="checkbox"/> <i>crave foods or other substances for stress relief</i>	<input type="checkbox"/> marijuana <input type="checkbox"/> alcohol <input type="checkbox"/> Xanax <input type="checkbox"/> Ativan <input type="checkbox"/> tobacco <input type="checkbox"/> sweets/starch <input type="checkbox"/> _____	GABA 100-500 mg as needed	GABA: calmness relaxation stress tolerance
	TYPE 4 Low Endorphins <input type="checkbox"/> very sensitive to emotional/physical pain <input type="checkbox"/> cry or tear up easily <input type="checkbox"/> history of chronic pain or sadness <input type="checkbox"/> <i>crave comfort, pleasure, or numbing from foods, drugs/ alcohol, pets, exercise, porn, self-harm, other</i>	<input type="checkbox"/> sweets <input type="checkbox"/> starches <input type="checkbox"/> chocolate <input type="checkbox"/> marijuana <input type="checkbox"/> alcohol <input type="checkbox"/> Vicoden <input type="checkbox"/> heroin <input type="checkbox"/> caffeine <input type="checkbox"/> tobacco <input type="checkbox"/> cheese <input type="checkbox"/> _____	DL-phenylalanine (DLPA) or D-phenylalanine (DPA) 500-1500 mg, as needed (use DLPA by 3:00 pm)	Endorphin: emotional or physical pain relief pleasure reward comforted easily by non-addictive treats like sunsets and hugs Inumbness when needed
	Type 5 Low Blood Sugar <input type="checkbox"/> irritable, shaky, stressed, especially if too long between meals <input type="checkbox"/> <i>cravings for sugar, starch, or alcohol</i>	<input type="checkbox"/> sweets <input type="checkbox"/> starches <input type="checkbox"/> alcohol	Glutamine 500-1500 mg as needed	Alternative fuel source for all brain cells: sense of stability and groundedness, blood sugar balance

Be sure to review the Amino Acid Precautions Chart before use of any aminos

USING AMINO ACIDS: PRECAUTIONS

Please check off and consult a knowledgeable health practitioner before taking *any* amino acids:

- ◆ You tend to react to supplements, foods or medications with unusual or uncomfortable symptoms
- ◆ You have serious physical illness, particularly cancer
- ◆ You have severe liver or kidney problems (e.g., lupus)
- ◆ You have an ulcer (amino acids are slightly acidic)
- ◆ You have schizophrenia, bipolar spectrum disorder, or other mental illness
- ◆ You are pregnant or nursing (individual amino acids are not recommended, but the amino blend, Total Amino Solutions may be used with your OB's permission.

Please check off and be cautious about trying the supplements indicated if you have:	Tyrosine or Phenylalanine ²	Tryptophan and 5-HTP	GABA	DLPA ²	Glutamine ¹	Melatonin
<input type="checkbox"/> High blood pressure	X			X		
<input type="checkbox"/> Migraine headaches	X			X		
<input type="checkbox"/> Bipolar spectrum tendencies ¹	X	5-HTP only		X	X	
<input type="checkbox"/> Overactive thyroid (Grave's disease), <input type="checkbox"/> Hashimoto's (in some cases ²)	X			X		
<input type="checkbox"/> Melanoma <input type="checkbox"/> PKU (phenylketonuria)	X			X		
<input type="checkbox"/> Severe or suicidal depression		5-HTP only			X	X
<input type="checkbox"/> You are taking medication that effect Serotonin eg MAO inhibitors for SSRI's, SNRI's or anti-migraine medications like Imitrex, or antimicrobials like Linzolid, (ask your pharmacist)		X				
<input type="checkbox"/> Asthma		X				
<input type="checkbox"/> A carcinoid tumor		X				X
<input type="checkbox"/> Excessively high cortisol (confirmed with a saliva test)		5HTP only				
<input type="checkbox"/> Very low blood pressure <input type="checkbox"/> Down's Syndrome			X			
<input type="checkbox"/> Any cancer, but especially lymphatic					X	

¹In bipolar spectrum, (i.e., significant, chronic mood swings to full blown manic/depression), glutamine can trigger mania. *Note:* glutamine can sometimes relieve bipolar depression without triggering mania. SSRI's and SNRI's, SAM-e, St. John's Wort, bright therapeutic lamps, and too much fish or flax oil may also trigger mania)

²These aminos can *sometimes* cause jitteriness in those with Hashimoto's Thyroiditis.

**Even if your doctor agrees that you can try amino acids (or any other nutrients),
if you experience discomfort of any kind after taking them, stop taking them immediately.**

Name _____ Date _____

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GAD-7 Anxiety

Over the <u>last two weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”

GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult