CONFIDENTIAL MEDICAL INFORMATION FORM

Name: _____ DOB: _____

Address: _____

_____

Preferred Phone: (_____)_____

Preferred Email: _____

How did you hear about us? _____

Emergency Contact: _____ How are you related? _____

Emergency Contact Phone: (_____)_____

Primary Care Provider: _____ Phone: (_____)_____

Mental Health Provider: _____ Phone: (_____)_____

Height: _____ Weight (used to appropriately dose ketamine): _____

Medical Conditions (Check all that apply):

- Migraines/Headaches
- Concussion(s)
- COPD/Emphysema
- Pain syndromes or chronic pain
- Immunosuppression
- Bleeding/clotting disorder
- Stroke/TIA
- Vein or artery disease
- Frequent UTIs or cystitis
- Dizziness or vertigo

Any other health condition(s) not mentioned above:

_____

_____

_____

Social History:

Do you smoke (cigarettes, cigars, pipe) or use smokeless tobacco? Yes / No / Quit

Do you vape or use e-cigarettes? Yes / No / Quit

Do you exercise regularly? Yes / No

How much alcohol do you drink? _____

Do you use any legal or illegal recreational drugs? Yes / No / Quit

[Reviewed by Medical Provider: _____ Date: _____]

Are you physically able to become pregnant? Yes / No

Family History:

	Self	Mother	Father	Sibling(s)	Partner	N/A
Depression						
Anxiety						
Bipolar						
OCD						
PTSD						
Schizophrenia						
Psychosis						
Suicidality						
Drug Use						
Alcohol Use						
Seizures						
Glaucoma						
High Blood Pressure						
Kidney Problems						
Liver Problems						
Heart disease						
Reaction to anesthesia						

Please list any known drug allergies and what your specific reaction was:

_____

_____

_____

Who is prescribing your medications (if applicable): _____

[Reviewed by Medical Provider: _____ Date: _____]

Please list your current medications, including over-the-counter, supplements, herbals, and topicals. Include those taken daily or just when needed. Please include dosage.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

What medications, treatments (TMS, ECT, meditation, acupuncture, etc.), or therapies (CBT, DBT, group therapy) have you tried in the past for your depression/anxiety/BPD/PTSD? Did they work?

1. _____ Yes / No / Temporarily
2. _____ Yes / No / Temporarily
3. _____ Yes / No / Temporarily
4. _____ Yes / No / Temporarily
5. _____ Yes / No / Temporarily

What are you hoping to achieve with IV ketamine therapy?

_____
_____
_____
_____
_____

Anything else we should know about you?

_____
_____
_____
_____

I certify that the above information is accurate and complete to the best of my ability. I understand that incomplete or falsified information may result in ineffective treatment and increased risk of side effects and/or unforeseen complications. I will request additional medical records from other providers *prior to treatment* if I am unable to provide complete information.

Patient Signature: _____ Date: _____

[Reviewed by Medical Provider: _____ Date: _____]