**Practice name**

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?

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:

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: