



Depression & Anxiety Patient Questionnaire

Complete the form below and submit via fax to 888-945-4264.

PATIENT INFORMATION

First Name *

Last Name *

Date of Birth * (mm/dd/yyyy)

Phone *

Patient Address *

City*

State*

Zip *

MENTAL HEALTH INFORMATION

My current Mental Health Provider is a: *

(Please check all that apply)

Psychiatrist (MD)

Psychologist

Primary Care Physician

Therapist / Counselor

I have no mental health provider at this time

Mental Health Provider Name (If self-referred or referred by someone other than a clinician, please tell us your source)

Mental Health Provider Phone Number

Mental Health Provider Address (Street, City, ST, Zip)

Primary Care Provider Name

Primary Care Provider Phone Number

Primary Care Provider Address (Street, City, ST, Zip)

Principle Psychiatric Diagnosis and Other Psychiatric Diagnoses *

Psychiatric Medications *

(Please list Dose and Frequency. Write N/A if none.)

Are you currently suicidal? *

Yes No

Have you ever attempted suicide in the past? *

Yes No

MEDICAL HISTORY

Patient's height*

Patient's weight*

Medical Conditions (Please check all that apply)

High Blood Pressure	Pulmonary Hypertension	Dizziness / Fainting	Abnormal Bleeding/Clotting Disorder
Heart Disease	Diabetes	Numbness / Tingling	Anemia
Chest Pains / Angina	Thyroid Problems	Unsteady Gait	Kidney Problems
Congestive Heart Failure	Seizures	Other Neurological Conditions	Liver Problems
Irregular Heart Rhythm	Stroke / TIA	Acid Reflux	Gynecologic Issues
Asthma	Headaches	Abdominal Pain	Muscle Disorders
Difficulty Exercising	Cognitive Problems	Nausea / Vomiting	Bone / Joint Disorders
COPD/Emphysema/Bronchitis	Visions / Voices	Other GI Conditions	Immunity Issues
Using Home Oxygen	Dementia	Chronic Pain	Infectious Diseases

Are you pregnant?

Date of last menstrual period (mm/dd/yyyy)

Breastfeeding (If applicable, are you breastfeeding?)

Yes No

Yes No

Previous Surgeries (write N/A if none)*

Current Non-Psychiatric Medications (write N/A if none) *

Have you or your direct family members ever had a serious adverse reaction to anesthesia? *

Yes No

If you answered yes, what was the reaction and to whom did it happen?

Drug Allergies (write N/A if none)*

Do you drink more than 2 alcoholic beverages per day? *

Yes No

Tobacco Use *

Yes No

Do you use recreational drugs (write N/A if none)?*
(If applicable, list drug and when last used)

Have you ever been treated for substance abuse?
(Please check all that apply)

Drugs Alcohol

Please list any other medical conditions not noted above and/or explanations of the conditions above that you feel would be helpful for us to know.

PATIENT ATTESTATION

By submitting this form, I certify that I have completed this Depression Questionnaire to the best of my ability.

I agree to seek immediate help should my symptoms worsen or I experience an increase in suicidal thoughts, feelings or urges.

I authorize a representative from Klarity,LLP to contact me to discuss treatment options for my condition(s). I also understand that the staff of Klarity Ketamine Clinic of Las Vegas will not start and maintain any prescribed treatment regimen if I am not currently under the care of a Mental Health Professional and maintain such care until the completion of my course of treatment.