KLARITY KETAMINE CLINIC of Las Vegas

Chronic Pain Patient Questionnaire

Complete the form below and submit online or via email to **records@klarityclinic.com** *or fax to* **888-945-4264**. *This form can also be downloaded and printed.*

PATIENT INFORMATION

First Name *

Last Name *

Date of Birth * (mm/dd/yyyy)

Phone *

Patient Address *

City*

State*

Zip *

PAIN MANAGEMENT INFORMATION

My current Pain Management Health Provider is a: *
(Please check all that apply)

- ☐ Pain Management Physician
- ☐ Neurologist
- ☐ Primary Care Physician
- ☐ I have no mental health provider at this time

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

Pain Management Provider Phone Number

Pain Management Provider Address (Street, City, ST, Zip)

Primary Care Provider Name

Primary Care Provider Phone Number

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

Principle Chronic Pain Diagnosis and Other Pain Diagnoses (Write N/A if unsure)*

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

MEDICAL HISTORY

Patient's height*

Patient's weight*

Medical Conditions (Please check all that apply)

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

Are you pregnant? ☐ Yes ☐ No

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

Breastfeeding (If applicable, are you breastfeeding?) ☐ Yes ☐ No

Previous Surgeries (write N/A if none)

Current Non-Pain 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.*

PRINT **SUBMIT**