

## **Pre-Infusion Questionnaire**

(Please print, fill out, and bring with you the day of your first infusion appointment.)

**1<sup>st</sup> Ketamine Infusion Appointment Date:**

**Name:**

**Date of Birth:**

**Address:**

**Phone Number:**

**Email:**

**Emergency Contact:**

**Referring physician or source (How did you hear about us?):**

\_\_\_\_\_

**Current Psychiatrist/Prescriber/Therapist/Primary Physician (circle one):**

\_\_\_\_\_

**\*Please note any medical conditions you are currently being treated for or have been diagnosed with:**

\_\_\_ Bleeding/clotting disorder(s)?

\_\_\_ High blood pressure?

\_\_\_ Seizure disorder or history of head trauma?

\_\_\_ Currently or may become pregnant?

\_\_\_ Currently taking narcotic/opioid painkillers? If so, what, and how much? How frequently? \_\_\_\_\_

\_\_\_ Currently taking benzodiazepines (Valium/diazepam, Klonopin/clonazepam, Ativan/lorazepam, Xanax/alprazolam) or sedatives? If so, what, and how much? How frequently? \_\_\_\_\_

\_\_\_ Are you currently on a dosage of Lamictal (lamotrigine) 100mg/day or higher?

\_\_\_ Ever had a history of a bad reaction, allergy, or bad outcome to anesthesia? If so, please explain: \_\_\_\_\_

**Any other conditions not listed above (PLEASE EXPLAIN):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*Please note any psychiatric conditions for which you are currently being treated or with which you have been diagnosed:**

\_\_\_ Major depression

\_\_\_ Post-partum depression

\_\_\_ Obsessive-compulsive disorder

\_\_\_ Post-traumatic stress disorder

\_\_\_ Generalized anxiety disorder

\_\_\_ Panic disorder

\_\_\_ Addictions to or dependence on (or a history of treatment for) painkillers/narcotics/opioids, sedatives, alcohol, or cocaine (please be honest—it's rather important to know, as ketamine can interact with these substances to your significant detriment.)

\_\_\_ Are you currently under the care of another ketamine clinic provider, seeking treatment at a pain clinic for pain disorder, or for the treatment of depression, anxiety, or PTSD? (IF YES, then we will need a copy of your medical records from your previous treatment provider BEFORE the 1<sup>st</sup> infusion takes place, and we will need to know the dosage and frequency with which the ketamine was given, AND a written consent from you that you will not seek ketamine treatment elsewhere while receiving it at this clinic.

I hereby certify that I have answered the above questions honestly and to the best of my ability, and understand that if I have willingly omitted information, or have provided false information, that I could have an unexpected outcome from the treatment, could be harmed from the treatment, or that I may be discharged as a patient.

Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_