

# Depression Questionnaire - Las Vegas

Please complete this online form and click "Send Form" at the end to send to our secure server.

**\*\* ALL RED STARRED QUESTIONS MUST HAVE AN ANSWER (write "None" if applicable) OR ELSE THE QUESTIONNAIRE WILL NOT BE PROCESSED THROUGH THE SYSTEM \*\***

\* Required

1. Email address \*

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## Contact Information

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2. First Name \*

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3. Last Name \*

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4. Date of Birth \*

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*Example: December 15, 2012*

5. Phone \*

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6. Home Address \*

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7. City/State/Zip \*

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## Mental Health Information

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**8. My current Mental Health Provider is a: \***

(Please check all that apply)

*Check all that apply.*

- Psychiatrist
- Psychologist
- Primary Care Physician
- Therapist
- I have no Mental Health Provider at this time

**9. Mental Health Provider Name**

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

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**10. Mental Health Provider Phone Number**

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**11. Mental Health Provider Address**

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**12. Primary Care Provider Name**

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**13. Primary Care Provider Phone Number**

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**14. Primary Care Provider Address**

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**15. Principle Psychiatric Diagnosis and Other Psychiatric Diagnoses \***

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**16. Psychiatric Medications \***

(Please list Dose and Frequency)

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**17. Have you ever attempted suicide in the past? \***

*Mark only one oval.*

- No
- Yes

**18. Are you currently suicidal? \***

*Mark only one oval.*

- No
- Yes

**Medical History**

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**19. What is your height? \***

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**20. What is your weight? \***

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**21. Medical Conditions**

(Please check all that apply)

*Check all that apply.*

- High Blood Pressure
- Heart Disease
- Chest Pains / Angina
- Congestive Heart Failure
- Irregular Heart Rhythm
- Asthma
- Difficulty Exercising
- COPD/Emphysema/Chronic 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

**22. Are you pregnant?**

*Mark only one oval.*

- No
- Yes
- N/A

**23. If not, when was your last menstrual period?**

\_\_\_\_\_  
*Example: December 15, 2012*

**24. Breastfeeding**

(If applicable, are you breastfeeding?)

*Mark only one oval.*

- No
- Yes

**25. 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.**

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**26. Current Non-Psychiatric Medications \***

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**27. Previous Surgeries \***

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

*Mark only one oval.*

- No
- Yes

29. If so, what was the reaction and whom did it happen to?

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30. Allergies \*

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31. Tobacco Use \*

Mark only one oval.

- No
- Yes

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

Mark only one oval.

- No
- Yes

33. Do you use recreational drugs? \*

(If applicable, list drug and when last used)

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34. Have you ever been treated for substance abuse?

(Please check all that apply)

Check all that apply.

- Drug
- Alcohol

## Patient Attestation

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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 may 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. I also consent to receiving emails from Klarity Ketamine Clinic for marketing purposes and I may opt out at anytime in the future by unsubscribing from Klarity's marketing list.

A copy of your responses will be emailed to the address you provided

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