FREEDOM
Ketamine Treatment Centers

Ketamine Intake

Ketamine Intake Form

Name:_____ Last 4: _____

Age: _____

Sex: _____

Race: ◯American Indian or Alaska Native ◯Asian ◯Black or African American
◯Hispanic or Latino ◯Native Hawaiian or Other Pacific Islander
◯White or Caucasian

Marital Status: ◯Single ◯Married ◯Divorced ◯Separated ◯Widowed

Highest degree of education: ◯Some high school ◯High school
◯Associates Degree ◯Some College
◯ College ◯Masters ◯Higher education (e.g., PhD, JD, MD, MBA)

Learning disability: ◯No

Are you experiencing chronic pain: ◯Yes ◯No

If yes: Duration of pain (months and years) _____
If yes: What is your diagnosis/pain location _____
If yes: Average Pain score (0= No pain to 10 =Most pain imaginable) _____

Current behavioral diagnoses (check all that apply):
◯PTSD and/or stress reaction
◯Depression Disorders (e.g., Major Depressive Disorder; Dysthimia; Postpartum Depression)
◯Anxiety Disorders (e.g., Generalized Anxiety Disorder; Social Anxiety; OCD; Specific Phobia)
◯Adjustment Disorders
◯Serious Mental Illness (Eg., Schizophrenia; Bipolar disorder; Paranoid and other psychotic disorders; Major Depression, severe; Schizoaffective disorders)
◯Substance abuse (e.g., Alcohol , Opioids, Illegal drugs; Nicotine)
◯Insomnia/Sleep Apnea/Sleep disorder
◯Other ◯N/A

Current Behavioral health treatments (check all that apply):
◯Individual therapy with a psychiatrist
◯Individual therapy with a therapist (psychologist, counselor, or social worker
◯Group therapy
◯Inpatient hospitalization for SI/HI and/or increase in behavioral health concerns
◯Inpatient treatment for behavioral health concerns
◯Intensive outpatient program (IOP)
◯Electroconvulsive therapy (ECT)
◯Transcranial magnetic stimulation (TMS)
◯Stellate Ganglion Block (SGB)
◯Ketamine treatment
◯Medication management, if you check this box please answer the below questions
◯Other ◯N/A

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◯Stellate Ganglion Block (SGB)
◯Ketamine treatment
◯Medication management, if you check this box please answer the below questions
◯Other ◯N/A

Current Behavioral health medications:
◯Antipsychotics (e.g., Thorazine, Haldol, Risperdal, Zyprexa, Seroquel, Geodon, Abilify, Invegal)
◯Antidepressants (e.g., Prozac, Celexa, Zoloft, Paxil, Lexapro, Effexor, Cymbalta, Wellbutrin, Tofranil, Anafranil)
◯Anti-anxiety medications (e.g., Klonopin, Atizan, Xanax, Buspar)
◯ADHD medications (e.g., Tialin, Metadate, Concerta, Daytrana, Adderall, Dexedrine, Dextrosat)
◯Beta blockers (e.g., Propanolol)
◯Mood stabilizers (e.g., Lithium, Depakote, Tegretol, Lamictal, Trileptal)

◯Other ◯N/A

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◯Other ◯N/A

Are you experiencing an memory concerns: ◯Yes ◯No
-If yes, have you undergone treatment or assessment of your memory concerns ◯Yes ◯No
-If yes, please provide a brief description of treatments:_____
_____

History of a TBI: ◯Yes ◯No

Current tobacco use: ◯Yes ◯No

-If yes: How many cigarettes/cigars/vapes a day _____
-How many years have you been using nicotine: _____years

Current Alcohol:

-Have you had an alcoholic drink in the past 12 months: ◯Yes ◯No
- How often do you have a drink: ◯Never ◯Monthly or Less
◯2-4x a month ◯ 2-3x a week ◯4 or more times a week
-How many drinks containing alcohol do you have on a typical day when you are drinking
◯1-2 ◯3-4 ◯5-6 ◯7-8 ◯10 or more
-How often do you have more than 6 drinks at one sitting?
◯Never ◯Less than monthly ◯Monthly
◯Weekly ◯Daily or almost daily

Current use of Substances:
-Have you used any substances (e.g., marijuana, cocaine, heroin) in the past 12 months: ◯Yes ◯No
-How often do you use substances: ◯Never ◯Monthly or Less ◯2-4x a month
◯ 2-3x a week ◯4 or more times a week

Current Medication List:

Name of Medication	Dosage	Frequency take medication

Patient height (Provider will fill this out):_____

Patient weight (Provider will fill this out): _____

Patient BMI (Provider will fill this out):_____

Dates of Infusion (Provider will fill this out): _____