Dar a Luz
Health Center

Ketamine Therapy Intake Form (Rev 04/26)

Name_____DOB_____ Phone_____

Sex_____ Pronouns_____ How did you hear about us?_____

Referring Provider (if any)_____
Name Phone

Primary Care Provider (if any)_____
Name Phone

Mental Health Provider (if any)_____
Name Phone

Race (check all that apply):

- ☐ Alaska or Native American
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latinx
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White or Caucasian

Partner Status:

- ☐ Single
- ☐ Partnered
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Highest Level of Education:

- ☐ Some high school
- ☐ HS graduate or GED
- ☐ Some college
- ☐ Associate's
- ☐ Bachelor's
- ☐ Master's
- ☐ Post Master's

Past Medical History **HEIGHT**_____ **WEIGHT**_____

Allergies (list):_____

Current Medications (prescription or over-the-counter):

Name of Medication	Dosage	Frequency	For How Long?

Do you have any of the following conditions?

Current	Past	
		Neurologic
		Migraines_____
		Seizures_____
		Stroke_____
		Neuromuscular disease_____
		A/V Malformations_____
		Learning Disorder_____
		Traumatic Brain Injury_____
		Other_____
		Metabolic/Endocrine
		Hypo- or Hyperthyroid_____
		Other_____
		Respiratory
		Shortness of breath_____
		Asthma_____
		Sleep apnea requiring CPAP_____
		Pulmonary hypertension_____
		Other_____
		Cardiovascular
		Uncontrolled high blood pressure_____
		Chest pain_____
		Heart murmur or abnormal heart rhythm_____
		Heart Attack_____
		Valve disease_____
		Heart failure_____
		Bleeding disorder_____
		Other_____
		GU/GI
		Recurrent UTIs_____
		Kidney disease_____
		Liver disease_____
		Other_____
		Infectious
		HIV_____
		Hepatitis_____
		Syphilis_____
		Other_____

Current **Past**

Hematology

☐ ☐ Bleeding disorder_____

☐ ☐ Cancer_____

☐ ☐ Other_____

Other History

☐ ☐ Substance Abuse (Alcohol, Cocaine, Methamphetamine, Heroin, Ketamine)

*If you use alcohol, how many drinks do you average per day?_____

☐ ☐ Other recreational drugs:_____

☐ ☐ Nicotine use (cigarettes, vape, nicotine patches) _____

☐ ☐ History of assault_____

☐ ☐ History of violent behavior_____

Females only

What form of birth control are you using, if any?_____

Is there any chance you could be pregnant? ☐ Yes ☐ No

Would you like a pregnancy test today? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Current **Past**

Mental/Behavioral diagnosis:

☐ ☐ Depression (including Postpartum Depression) _____

☐ ☐ Anxiety (any) _____

☐ ☐ PTSD_____

☐ ☐ OCD_____

☐ ☐ Psychosis_____

☐ ☐ Other Diagnosis (Schizophrenia, Bipolar, Schizoaffective disorders)_____

Mental/Behavioral health treatments:

☐ ☐ Individual therapy _____

☐ ☐ Group therapy_____

☐ ☐ Inpatient hospitalization for suicidal or homicidal ideation, increase in concerning behaviors/thoughts_____

☐ ☐ Intensive outpatient program_____

☐ ☐ Ketamine treatment_____

☐ ☐ Mental health medication management_____

☐ ☐ Other treatments_____

Mental/Behavioral health medications

☐ ☐ Anti-depressants_____

☐ ☐ Anti-anxiety medications_____

☐ ☐ ADHD/Stimulant medications_____

☐ ☐ Anti-psychotics_____

☐ ☐ Betablocker (Propranolol) _____

☐ ☐ Mood Stabilizers_____

☐ ☐ MAO Inhibitors (Isocarboxazid/Marplan, Phenelzine/Nardil, Selegiline/Emsam, Tranylcypromine/Parnate)_____