Dar a Luz
Health Center

Ketamine Therapy Intake Form (Rev 02/26)

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

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)_____