Tremayne Center for Medicine

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Ketamine Infusion New Patient Questionnaire

Name: _____ Date of Birth: _____/_____/_____
LAST FIRST MIDDLE

Address: _____
STREET CITY STATE ZIP

Phone Number: _____

Email address: _____

Emergency Contact Name

Name: _____ Relation: _____ Phone: _____

Please list the name and contact information for your primary treatment providers, including your primary care provider, psychiatrist, and / or therapist.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

What acute or chronic medical conditions (e.g.,, diabetes, asthma, pneumonia, etc.) have you had diagnosed, if any?

_____ _____ _____ _____

Have you ever been diagnosed with high blood pressure?

Yes No

Have you ever been diagnosed with dementia or some other form of cognitive impairment?*

Yes No

Have you ever had a seizure?

Yes No If so, when was the last time? _____

Have you ever had brain surgery?

Yes No If so, for what? _____

Do you have any known structural lesions (e.g., tumors, blood vessel malformations, hydrocephalus) in your brain?

Yes No If so, what? _____

Are you pregnant or breast-feeding, or do you plan on becoming pregnant?

Yes No

Do you have any chronic pain issues?

Yes No

When was the onset of your chronic pain, and how has it progressed?

_____

Was there an initial cause of your chronic pain?

_____

Are there any other symptoms associated with your chronic pain (swelling, skin changes, dry skin, lack of sweating, pain to light touch)?

_____

Have you had any procedures for your pain? (Epidurals, blocks, radiofrequency ablation, etc.)

_____

What medications have helped you with your chronic pain in the past?

_____

Do you have any allergies to medications?

_____

Are you currently taking MAOI Inhibitors [Selegiline(Emsam) Isocarboxazid(Marplan) Phenelzine(Nardil) Tranylcypromine(Parnate)]?

Yes No If so, what? _____

Which medications / supplements are you taking now (please include dosages and any as needed medications)?

_____

_____

_____

_____

_____

_____

_____

Please mark any of the below medications that you KNOW that you have either taken in the past or are taking now?

- ☐ Fluoxetine (Prozac)
- ☐ Paroxetine (Paxil)
- ☐ Sertraline (Zoloft)
- ☐ Fluvoxamine (Luvox)
- ☐ Citalopram (Celexa)
- ☐ Escitalopram (Lexapro)
- ☐ Venlafaxine (Effexor)
- ☐ Duloxetine (Cymbalta)
- ☐ Vilazodone (Viibryd)
- ☐ Desvenlafaxine (Pristiq)
- ☐ Vorioxetine (Brintellix)
- ☐ Trazodone (Desyrel)
- ☐ Amitriptyline (Elavil)
- ☐ Imipramine (Tofranil)
- ☐ Clomipramine (Anafranil)
- ☐ Selegiline (Emsam)
- ☐ Phenelzine (Nardil)
- ☐ Nortriptyline (Pamelor)
- ☐ Tranylcypromine (Parnate)
- ☐ Isocarboxazid (Marplan)
- ☐ Linezolid (Zyvox)
- ☐ Lithium (Lithobid)
- ☐ Valproic Acid (Depakote, Depakene)
- ☐ Carbamazepine (Tegretol)
- ☐ Oxcarbazepine (Trileptal)
- ☐ Lamotrigine (Lamictal)
- ☐ Gabapentin (Neurontin)
- ☐ Topiramate (Topamax)
- ☐ Pregabalin (Lyrica)
- ☐ Fluphenazine (Prolixin)
- ☐ Perphenazine (Trilafon)
- ☐ Chlorpromazine (Thorazine)
- ☐ Haloperidol (Haldol)
- ☐ Ziprasidone (Geodon)
- ☐ Iloperidone (Fanapt)
- ☐ Quetiapine (Seroquel)
- ☐ Risperidone (Risperdal)
- ☐ Paliperidone (Invega)
- ☐ Lurasidone (Latuda)
- ☐ Asenapine (Saphris)
- ☐ Clozapine (Clozaril)
- ☐ Brexpiprazole (Rexulti)
- ☐ Cariprazine (Vraylar)
- ☐ Aripiprazole (Abilify)
- ☐ Clonazepam (Klonopin)
- ☐ Diazepam (Valium)
- ☐ Alprazolam (Xanax)
- ☐ Temazepam (Restoril)
- ☐ Lorazepam (Ativan)
- ☐ Thyroid hormone
- ☐ Buspirone (Buspar)

Are you currently taking any opiate pain medications?

○ Yes ○ No If so, how long have you been on the medications? _____

Are you currently taking any benzodiazepines (such as lorazepam, alprazolam, clonazepam or diazepam, temazepam, etc.)?

○ Yes ○ No If so, how long have you been on the medications? _____

Which psychiatric diagnoses do you feel currently apply to you (e.g., Major depressive disorder, Bipolar disorder, Post-traumatic stress disorder, etc.)?

_____

Have you ever been diagnosed with a psychotic disorder, or have you previously had any psychotic symptoms (e.g., hearing voices, seeing things, having false beliefs, being paranoid out of proportion to reality)?

Yes No If so, please explain. _____

Have you ever made a suicide attempt before or engaged in any prior self-injury (including cutting behavior)?

Yes No

If so, when was the last time and what did you do? _____

Have you ever been psychiatrically hospitalized?

Yes No If so, when was the last time? _____

Are you currently depressed?

Yes No

If so, approximately how long has your current episode of depression lasted for? *

_____

Have you recently had suicidal thoughts?

Yes No

If so, what coping mechanisms do you utilize to manage the thoughts and depression?

_____

Are you currently in psychotherapy?

Yes No

When was the last time that you saw a psychiatrist? _____

The yes / no questions listed below relate to your thoughts and feelings. If the way you have been in recent weeks or months differs from the way you usually are, please answer based on when you were your usual self.

Do you feel that you have a good sense of who you are, of what you value and believe?

Yes No

Do you have a history of repeated chaotic and / or volatile romantic relationships?

Yes No

Do you feel like you ride an emotional roller coaster on most days, i.e., such that you can go from being happy to angry to sad very quickly and many times throughout a day?

Yes No

Do you have a hard time controlling your impulses, so that you are quick to act on whatever it is you feel before thinking about your actions or their consequences?

Yes No

Do you have a lot of anger and / or rage inside of you?

Yes No

Do you suffer with chronic feelings of emptiness?

Yes No

Are you quick to feel suicidal if things don’t go your way, or if you’re having a bad day?

Yes No

Have you had experiences where you feel like you’re seeing shadows out of the corners of your eyes, or hearing your name being called when no one is around?

Yes No

Do you have a fear of being abandoned by others?

Yes No

Do you frequently get irritated or angry if others don't recognize your unique talents and abilities?

Yes No

Are you good at handling criticism from others?

Yes No

Do you feel that it's a difficult for you to catch a break, that something or someone else frequently stands in the way of moving forward in your life?

Yes No

Have you used any recreational drugs (including cannabis) or abused prescription drugs within the past 3 months?

Yes No

Have you gotten drunk from alcohol within the past 3 months?

Yes No

Have you yourself thought or has anyone else told you that your drug or alcohol use is a problem?

Yes No