ALBUQUERQUE INTEGRATIVE KETAMINE

Patient Intake Form

PATIENT DETAILS

PATIENT NAME | DOB (MM/DD/YYYY) | DATE (MM/DD/YYYY) | ☐ MALE ☐ FEMALE ☐ OTHER GENDER

STREET ADDRESS | CITY | STATE | ZIP

HOME PHONE (### - ### - ####) | MOBILE PHONE (###) ###-#### | SOCIAL SECURITY (### - ## - ####)

EMAIL | ETHNICITY | WEIGHT (LBS) | HEIGHT

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED MARITAL STATUS

☐ ENGLISH ☐ SPANISH ☐ OTHER PRIMARY LANGUAGE

SPOUSE FIRST NAME | SPOUSE PHONE (### - ### - ####)

EMERGENCY CONTACT

EMERGENCY CONTACT NAME | RELATIONSHIP | EMAIL

HOME PHONE (### - ### - ####) | MOBILE PHONE (###) ###-#### | SOCIAL SECURITY (### - ## - ####)

TREATING PHYSICIANS

PRIMARY CARE PHYSICIAN | PHONE (### - ### - ####)

CLERGY/SPIRITUAL GUIDE NAME | PHONE (### - ### - ####)

ALLERGIES

LIST ALLERGIES

MEDICATIONS

LIST CURRENT MEDICATIONS WITH DOSAGES

FAMILY HISTORY

☐ RELATIVE ☐ MOTHER ☐ FATHER ☐ SIBLINGS ☐ GRANDPARENTS

ANY FAMILY HISTORY SCHIZOPHRENIA, PSYCHOSIS?

SURGICAL HISTORY

DESCRIPTION/TYPE & YEAR

ALBUQUERQUE INTEGRATIVE KETAMINE

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MEDICAL HISTORY

Arthritis Conditions	YES ☐ NO ☐	Fibromyalgia	YES ☐ NO ☐	Menopause	YES ☐ NO ☐
Asthma	YES ☐ NO ☐	GERD	YES ☐ NO ☐	Migraines/Headaches	YES ☐ NO ☐
Atrial Fibrillation	YES ☐ NO ☐	Heart Disease	YES ☐ NO ☐	Neuropathy	YES ☐ NO ☐
Bleeding Problems	YES ☐ NO ☐	Hyperlipidemia	YES ☐ NO ☐	Osteoporosis	YES ☐ NO ☐
Coronary Artery Disease	YES ☐ NO ☐	Hypertension	YES ☐ NO ☐	Pulmonary Embolism	YES ☐ NO ☐
Cancer	YES ☐ NO ☐	Hypothyroidism	YES ☐ NO ☐	Seizure Disorders	YES ☐ NO ☐
Chest Pain	YES ☐ NO ☐	Infection Problems (HIV, Hep C)	YES ☐ NO ☐	Shortness of Breath	YES ☐ NO ☐
Congestive Heart Failure	YES ☐ NO ☐			Sinus Conditions	YES ☐ NO ☐
Chronic Fatigue Syndrome	YES ☐ NO ☐	Insomnia	YES ☐ NO ☐	Stroke	YES ☐ NO ☐
Depression	YES ☐ NO ☐	Irritable Bowel Syndrome	YES ☐ NO ☐	Tremors	YES ☐ NO ☐
Drug/Alcohol Abuse	YES ☐ NO ☐	Kidney Problems	YES ☐ NO ☐	Other medical problems	YES ☐ NO ☐

LIST OTHER

HEALTH CONCERNS

WHAT'S YOUR PRIMARY HEALTH CONCERN?

APPROXIMATELY WHEN DID THIS ISSUE BEGIN?

☐ YES ☐ NO
DOES THE ISSUE CAUSE YOU PAIN?

IF SO, WHERE?

☐ INCREASED ☐ DECREASED ☐ UNCHANGED
HOW HAS THE PAIN CHANGED SINCE IT BEGAN?

PAIN ASSESSMENT

☐ GRADUALLY ☐ SUDDENLY
HOW QUICKLY DID YOUR CURRENT PAIN BEGIN?

☐ CONSTANTLY ☐ OCCASIONALLY ☐ RARELY
HOW OFTEN DOES YOUR PAIN OCCUR?

☐ MORNING ☐ AFTERNOON ☐ EVENING ☐ NIGHT
WHEN IS YOUR PAIN AT ITS WORST?

WHAT ARE YOUR CURRENT SYMPTOMS?

☐ SHOOTING ☐ SHOOTING ☐ SPASMING ☐ SQUEEZING ☐ NUMBNESS
☐ ACHING ☐ CRAMPING ☐ DULL ☐ HOT/BURNING ☐ STABBING/SHARP
CHECK ANY OF THE FOLLOWING THAT DESCRIBE YOUR PAIN

DESCRIBE YOUR PAIN

SOCIAL HISTORY

☐ YES ☐ NO
DO YOU CURRENTLY CONSUME ALCOHOL?

HOW MANY DRINKS PER WEEK?

☐ YES ☐ NO
DO YOU CONSUME CAFFEINE?

APPROXIMATELY HOW MUCH PER DAY?

☐ YES ☐ NO
DO YOU CURRENTLY SMOKE?

HOW OFTEN PER WEEK?

☐ YES ☐ NO
DO YOU EXERCISE?

HOW OFTEN DO YOU EXERCISE?

☐ TOBACCO ☐ MARIJUANA ☐ OTHER
WHAT DO YOU SMOKE?

☐ YES ☐ NO
DO YOU CURRENTLY USE ANY OTHER DRUGS?

☐ YES ☐ NO
WHAT OTHER DRUGS DO YOU TAKE?

☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ RARELY
HOW OFTEN?

REPRODUCTIVE HEALTH

☐ YES ☐ NO
ARE YOU PLANNING A PREGNANCY?

☐ YES ☐ NO
ARE YOU PREGNANT NOW?

WHEN WAS YOUR LAST MENSTRUAL CYCLE?

PATIENT CONSENT

PATIENT NAME

PATIENT SIGNATURE

DATE (MM/DD/YYYY)

By signing below, I hereby acknowledge, agree, and authorize all of the following:

a) Accurate Information. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.

b) Patient Rights and Responsibilities. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this notice prior to signing.

c) Release of Medical Information. I authorize the release of my health information to the healthcare facility in accordance with their privacy practices.

d) Consent for Treatment. I grant permission for treatment using the health information I provide for medical care as necessary.

e) Consent to Communication. I agree to receive healthcare updates and communications via phone, email, or other channels.

f) Acknowledgment. I authorize the facility to retrieve and release medical history for treatment and insurance purposes.

☐ I AGREE ☐ I DISAGREE

ALBUQUERQUE INTEGRATIVE KETAMINE

Altman Mania Scale

PATIENT NAME | DOB (MM/DD/YYYY) | DATE (MM/DD/YYYY)

There are 5 groups of statements in this questionnaire, read each group of statements carefully. You should choose the statement in each group that best describes the way you have been feeling for the past week.

Please note: The word "occasionally" when used here means once or twice; "often" means several times or more and "frequently" means most of the time.

A. Positive Mood

1 ◯ I do not feel happier or more cheerful than usual.
2 ◯ I occasionally feel happier or more cheerful than usual.
3 ◯ I often feel happier or more cheerful than usual.
4 ◯ I feel happier or more cheerful than usual most of the time.
5 ◯ I feel happier or more cheerful than usual all of the time.

B. Self-Confidence

1 ◯ I do not feel more self-confident than usual.
2 ◯ I occasionally feel more self-confident than usual.
3 ◯ I often feel more self-confident than usual.
4 ◯ I feel more self-confident than usual.
5 ◯ I feel extremely self-confident all of the time.

C. Sleep Patterns

1 ◯ I do not need less sleep than usual.
2 ◯ I occasionally need less sleep than usual.
3 ◯ I often need less sleep than usual.
4 ◯ I frequently need less sleep than usual.
5 ◯ I can go all day and night without any sleep and still not feel tired.

D. Speech

1 ◯ I do not talk more than usual.
2 ◯ I occasionally talk more than usual.
3 ◯ I often talk more than usual.
4 ◯ I frequently talk more than usual.
5 ◯ I talk constantly and cannot be interrupted.

E. Activity Level

1 ◯ I have not been more active (either socially, sexually, at work, home, or school) than usual.
2 ◯ I have occasionally been more active than usual.
3 ◯ I have often been more active than usual.
4 ◯ I have frequently been more active than usual.
5 ◯ I am constantly active or on the go all the time.

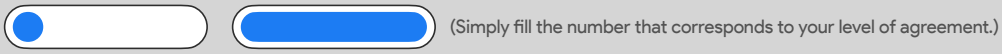
Total Score (add your scores from section A through E):

ALBUQUERQUE INTEGRATIVE KETAMINE

Spirituality Assessment

PATIENT NAME | DOB (MM/DD/YYYY) | DATE (MM/DD/YYYY)

Please indicate your level of agreement to the following statements by circling the appropriate number that corresponds with the answer key.



(Simply fill the number that corresponds to your level of agreement.)

1 = Strongly Disagree

5 = Strongly Agree

1 2 3 4 5	1. I find meaning in my life experiences.
1 2 3 4 5	2. I have a sense of purpose.
1 2 3 4 5	3. I am happy about the person I have become.
1 2 3 4 5	4. I see the sacredness in everyday life.
1 2 3 4 5	5. I meditate to gain access to my inner spirit
1 2 3 4 5	6. I live in harmony with nature.
1 2 3 4 5	7. I believe there is a connection between all things that I cannot see but can sense.
1 2 3 4 5	8. My life is a process of becoming.
1 2 3 4 5	9. I believe in a Higher Power/Universal Intelligence.
1 2 3 4 5	10. I believe that all living creatures deserve respect.
1 2 3 4 5	11. The earth is sacred.
1 2 3 4 5	12. I value maintaining and nurturing my relationships with others.
1 2 3 4 5	13. I use silence to get in touch with myself.
1 2 3 4 5	14. I believe that nature should be respected.
1 2 3 4 5	15. I have a relationship with a Higher Power/Universal Intelligence.
1 2 3 4 5	16. My spirituality gives me inner strength.
1 2 3 4 5	17. I am able to receive love from others.
1 2 3 4 5	18. My faith in a Higher Power/Universal Intelligence helps me cope during challenges in my life.
1 2 3 4 5	19. I strive to correct the excesses in my own lifestyle patterns/practices.
1 2 3 4 5	20. I respect the diversity of people.
1 2 3 4 5	21. Prayer is an integral part of my spiritual nature.
1 2 3 4 5	22. At times, I feel at one with the universe.
1 2 3 4 5	23. I often take time to assess my life choices as a way of living my spirituality.

ALBUQUERQUE INTEGRATIVE KETAMINE

PTSD Assessment

PATIENT NAME _____ DOB (MM/DD/YYYY) _____ DATE (MM/DD/YYYY) _____

Please indicate your level of agreement to the following statements by circling the appropriate number that corresponds with the answer key.

1 = Not at all | 2 = A little bit | 3 = Moderately | 4 = Quite a bit | 5 = Extremely

1 2 3 4 5	1. Repeated, disturbing, and unwanted memories of the stressful experience?
1 2 3 4 5	2. Repeated, disturbing dreams of the stressful experience?
1 2 3 4 5	3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?
1 2 3 4 5	4. Feeling very upset when something reminded you of the stressful experience?
1 2 3 4 5	5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?
1 2 3 4 5	6. Avoiding memories, thoughts, or feelings related to the stressful experience?
1 2 3 4 5	7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?
1 2 3 4 5	8. Trouble remembering important parts of the stressful experience?
1 2 3 4 5	9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?
1 2 3 4 5	10. Blaming yourself or someone else for the stressful experience or what happened after it?
1 2 3 4 5	11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?
1 2 3 4 5	12. Loss of interest in activities that you used to enjoy?
1 2 3 4 5	13. Feeling distant or cut off from other people?
1 2 3 4 5	14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?
1 2 3 4 5	15. Irritable behavior, angry outbursts, or acting aggressively?
1 2 3 4 5	16. Taking too many risks or doing things that could cause you harm?
1 2 3 4 5	17. Being "superalert" or watchful or on guard?
1 2 3 4 5	18. Feeling jumpy or easily startled?
1 2 3 4 5	19. Having difficulty concentrating?
1 2 3 4 5	20. Trouble falling or staying asleep?

ALBUQUERQUE INTEGRATIVE KETAMINE

Impact of Event Assessment

PATIENT NAME | DOB (MM/DD/YYYY) | DATE (MM/DD/YYYY)

Please indicate your level of agreement to the following statements by circling the appropriate number that corresponds with the answer key.

1 = Not at all | 2 = A little bit | 3 = Moderately | 4 = Quite a bit | 5 = Extremely

1 2 3 4 5	1. Any reminder brought back feelings about it
1 2 3 4 5	2. I had trouble staying asleep
1 2 3 4 5	3. Other things kept making me think about it
1 2 3 4 5	4. I felt irritable and angry
1 2 3 4 5	5. I avoided letting myself get upset when I thought about it or was reminded of it
1 2 3 4 5	6. I thought about it when I didn't mean to
1 2 3 4 5	7. I felt as if it hadn't happened or wasn't real
1 2 3 4 5	8. I stayed away from reminders about it
1 2 3 4 5	9. Pictures about it popped into my mind
1 2 3 4 5	10. I was jumpy and easily startled
1 2 3 4 5	11. I tried not to think about it
1 2 3 4 5	12. I was aware that I still had a lot of feelings about it, but I didn't deal with them
1 2 3 4 5	13. My feelings about it were kind of numb
1 2 3 4 5	14. I found myself acting or feeling as though I was back at that time
1 2 3 4 5	15. I had trouble falling asleep
1 2 3 4 5	16. I had waves of strong feelings about it
1 2 3 4 5	17. I tried to remove it from my memory
1 2 3 4 5	18. I had trouble concentrating
1 2 3 4 5	19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart
1 2 3 4 5	20. I had dreams about it
1 2 3 4 5	21. I felt watchful or on-guard
1 2 3 4 5	22. I tried not to talk about it

ALBUQUERQUE INTEGRATIVE KETAMINE

Patient Health Questionnaire & General Anxiety Disorder

PATIENT NAME | DOB (MM/DD/YYYY) | DATE (MM/DD/YYYY)

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please fill your answers, then add the sum in the field.

1 = Not at all | 2 =Several days | 3 = Moderately | 4 = More than half the days | 5 = Nearly every day

○ 1 ○ 2 ○ 3 ○ 4 ○ 5	1. Little interest or pleasure in doing things.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	2. Feeling down, depressed, or hopeless.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	3. Trouble falling or staying asleep, or sleeping too much.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	4. Feeling tired or having little energy.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	5. Poor appetite or overeating.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	7. Trouble concentrating on things, such as reading the newspaper or watching television.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	9. Thoughts that you would be better off dead, or of hurting yourself in some way.

Total Score (add your column scores):

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

○ Not difficult at all ○ Somewhat difficult ○ Very Difficult ○ Extremely Difficult

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please fill your answers, then add the sum in the field.

1 = Not at all | 2 =Several days | 3 = Moderately | 4 = More than half the days | 5 = Nearly every day

○ 1 ○ 2 ○ 3 ○ 4 ○ 5	1. Feeling nervous, anxious, or on edge.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	2. Not being able to stop or control worrying.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	3. Worrying too much about different things.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	4. Trouble relaxing.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	5. Being so restless that it's hard to sit still.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	6. Becoming easily annoyed or irritable.
○ 1 ○ 2 ○ 3 ○ 4 ○ 5	7. Feeling afraid as if something awful might happen.

Total Score (add your column scores):

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

○ Not difficult at all ○ Somewhat difficult ○ Very Difficult ○ Extremely Difficult

ALBUQUERQUE INTEGRATIVE KETAMINE

Quality of Life Assessment

PATIENT NAME _____ DOB (MM/DD/YYYY) _____ DATE (MM/DD/YYYY) _____

Under each heading, please select the ONE box that best describes your health TODAY.

MOBILITY

- ☐ I have no problems in walking about
- ☐ I have slight problems in walking about
- ☐ I have moderate problems in walking about
- ☐ I have severe problems in walking about
- ☐ I am unable to walk about

SELF-CARE

- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing or dressing myself
- ☐ I have severe problems washing or dressing myself
- ☐ I am unable to wash or dress myself

USUAL ACTIVITIES

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

PAIN/DISCOMFORT

- ☐ I have no pain o r discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

ANXIETY/DEPRESSION

- ☐ I am not anxious or depressed
- ☐ I am slightly anxious or depressed
- ☐ I am moderately anxious o r depressed
- ☐ I am severely anxious or depressed
- ☐ I am extremely anxious or depressed