Health Screening Questionnaire

Please fax or email your completed questionnaire
Fax: (844) 633-2390 **Email:** forms@chicagoivsolution.com

IV SOLUTION
Ketamine Centers of Chicago

Date:

Personal Information

First name	
Middle name	
Last name	
Gender	
Home address	
City/State	
Home phone	
Mobile phone	
Home fax	
Email address	
Date of Birth (MM/DD/YYYY)	

Please answer the below screening questions to the best of your ability

For what diagnosis or condition are you seeking ketamine therapy?	
Have you been diagnosed with depression? What treatments for depression have you undergone? -Antidepressant meds -Psychotherapy -Other	
For how many years have you had clinical depression?	
Do you have a chronic pain condition? What was the Diagnosis?	
Do you have any current or history of intracranial pathology?	

Have you ever been treated for any other psychiatric condition? What was the diagnosis?	
Are you currently or have you in the past experienced suicidal ideation?	
Do you have any history of headaches? What cause? How treated?	
Do you have any history of seizures? Treatment?	
Do you have high blood pressure? Are you taking medication? Does it control your blood pressure?	
Are you currently physically dependent on narcotics?	
Are you currently pregnant or breastfeeding?	
Do you have any allergies to medications? List reaction:	
Please provide a list of all your current medications including name, dosage, frequency, and condition used for:	

Primary Care Physician

Name	
Address	
Phone number	

Psychiatrist or Mental Health Professional

Name	
Address	
Phone number	

Emergency Information

Emergency contact's name	
Relationship	
Address	
Phone number(s)	