Health Screening Questionnaire

Please Fax completed form to 844-633-2390 or email to forms@chicagoivsolution.com

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?	
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?	
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 of 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)	

How did you hear about us? _____

Please send securely via Fax to 1-844-633-2390 or email to forms@chicagoivsolution.com

_____ By initialing here, I attest that the above statements are true and correct to the best of my knowledge.