The Ketamine Wellness Clinic of Orange County www.ketamineoc.com

Patient Health Assessment Form

Name:(Last, First)
Email:
Address:
Phone: ()
Date of Birth:/
Referring Provider.
Specialty:
Specialty: Telephone Number: () Date of next appointment:/
Date of next appointment:/
Current Medication(s):
Do you have any medication allergies? Yes/No (If Yes, List):
Have you been diagnosed with high blood pressure? Yes/No Have you been diagnosed with a heart or lung disease or condition? Yes/No (if yes, List):
Have you been diagnosed with any neurological conditions? (Stroke, Migraine Headaches Epilepsy, Concussions) Yes/No (If yes, List)
Do you have Glaucoma? Yes/No Are you pregnant or breastfeeding (Females)? Yes/No Do you have any other medical problems that have been diagnosed or treated? Yes/No (If yes, list):
Have you been diagnosed with any of the following? (Circle):
Depression
Post-Traumatic Stress Disorder,
Schizophrenia, Obsessive-compulsive disorder,
Generalized Anxiety Disorder,
Bipolar Disorder,
Drug or Alcohol Dependency,
Fibromyalgia,
Reflex Sympathetic Dystrophy (RSD)/or Complex Regional Pain Syndrome (CRPS)? Neuropathic Pain
Migraines/Persistent Daily Headaches
(other): Have you ever been treated at an inpatient facility for any of the above diagnosis?
Yes/No (if yes, which facility/dates
No (If yes, list)
Have you ever been treated with electroconvulsive therapy (ECT)? Yes/No Please add any other pertinent personal or family health information here:
I attest that the above personal health information is correct and complete:
Signed: Date://