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

HQ

Patient Health Assessment Form

Name:(Last, First) _____
Email: _____
Address:_____
_____
Phone: ( )_____**Date of Birth**: _____/_____/_____
Referring Provider:_____**Specialty**:_____
Telephone Number: ( )_____
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,
Migraines or Daily Headaches,
Reflex Sympathetic Dystrophy (RSD)/or Complex Regional Pain Syndrome (CRPS),
Neuropathic Pain
(other): _____
Have you ever been treated at an inpatient facility for any of the above diagnosis?
Yes/No (if yes, which facility/dates) _____
Do you have a family history of psychiatric disorders and/or chemical dependency?
Yes/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: ___/___/_____