PATIENT HEALTH ASSESSMENT

Please complete and send this form to Ketamine Wellness Clinic of Orange County.

Patient's Name (Last, First) ____

Date of Birth ______/______/______ Phone (______) ______-__________

Email ____

Address ____

City ______________________________ State ________ Zip ______________

Referring Provider ______________________________ Specialty ______________________________

Provider's Phone (______) ______-__________

Patient Information

Date of Next Appointment ______/______/______

Current Medication(s) ____

Do you have any medication allergies? ☐ Yes ☐ No

(If Yes, list all) ____

Have you been diagnosed with any of the following?

High blood pressure? ☐ Yes ☐ No

Heart or lung disease or condition? ☐ Yes ☐ No

Neurological conditions? (Stroke, Migraine Headaches, Epilepsy, Concussions) ☐ Yes ☐ No

(If Yes, list all) ____

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 all) ____

Please continue on next page.

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Have you been diagnosed with any of the following? ***Check the box(es) that apply.***

- ☐ Depression
- ☐ Schizophrenia
- ☐ Generalized Anxiety Disorder
- ☐ Drug or Alcohol Dependency
- ☐ Reflex Sympathetic Dystrophy (RSD) / or Complex Regional Pain Syndrome (CRPS)?
- ☐ Post-Traumatic Stress Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Bipolar Disorder
- ☐ Fibromyalgia
- ☐ 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) ____

Do you have a family history of psychiatric disorders and/or chemical dependency? ☐ Yes ☐ No

(If Yes, list all) ____

Have you ever been treated with electroconvulsive therapy (ECT)? ☐ Yes ☐ No

Please add any other pertinent personal or family health information here ______________________

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Notes ____

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I attest that the above personal health information is correct and complete.

Patient Signature ____

Date ______/______/______ **Phone (______)** ______-__________