PATIENT INTAKE FORM

NEW LIFE
KETAMINE CLINIC

PERSONAL INFORMATION (* Required Field)

For optimal user experience, we recommend completing this form on a computer or tablet, if you have any questions about the patient intake form, our staff is available during regular business hours to assist at 937-489-5994.

Name* First Last Date of birth*

Address*
Street City State/Province/Region Zip/Postal code Country

RESPONSIBLE PARTY

Responsible Party's SSN*

Address(if different)
Street City State/Province/Region Zip/Postal Code Country

Home Phone (if different)* Home Phone (if different)* Cell Phone (if different)*

Do you give our staff permission to leave a voicemail regarding your inquiry into NLKC in the event we cannot reach you?* ◯ Yes ◯ No

Email* Preferred contact method*

How did you find us?*

Emergency contact name* Emergency contact phone*

Person's name responsible for driving you home*

What condition(s) are you seeking treatment for at our clinic?* Please make all that apply.

- ☐ Depression
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Anxiety
- ☐ Suicidal
- ☐ Ideation
- ☐ Other:_____

Please list any or all anesthesia problems with you or your family members*
If none, type "n/a" or "none"

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Past surgical History ☐ None

Allergies

Medication/Supplement/Food	Reaction

I am currently compliant with all medications prescribed by my mental health provider.

Current Medications/Supplements ☐ None

Name/Dose	Reson for Use

◯ Yes ◯ No If no, please explain:

PAST MEDICAL HISTORY

Do you have any of these conditions? Check appropriate box and provide date of onset.

☐ *Past Condition* ☐ *Current Condition*

NEUROLOGICAL/MOOD

☐ ☐ Depression _____
☐ ☐ Anxiety _____
☐ ☐ PTSD _____
☐ ☐ Insomnia _____
☐ ☐ Schizophrenia _____
☐ ☐ Hallucinations _____
☐ ☐ ADD/ADHD _____
☐ ☐ Suicidal _____
☐ ☐ History of Mental Health Crisis _____
_____
☐ ☐ Seizures _____
☐ ☐ Stroke _____
☐ ☐ Neuromuscular Disease _____
☐ ☐ History of Psychiatric Admission _____
_____
☐ ☐ Other _____

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☐ *Past Condition* ☐ *Current Condition*

METABOLIC/ ENDOCRINE

- ☐ ☐ Hypothyroid (underactive) _____
- ☐ ☐ Hyperthyroidism (overactive thyroid)_____
- ☐ ☐ Other_____

GU/GI

- ☐ ☐ Kidney Disease_____
- ☐ ☐ Liver Disease _____
- ☐ ☐ Other_____

CARDIOVASCULAR

- ☐ ☐ High Blood Pressure _____
- ☐ ☐ Controlled/Uncontrolled _____
- ☐ ☐ Chest Pain _____
- ☐ ☐ Heart Murmur_____
- ☐ ☐ Heart Attack _____
- ☐ ☐ Valve Disease _____
- ☐ ☐ Heart Failure _____
- ☐ ☐ Abnormal Heart Rhythm _____
- ☐ ☐ Bleeding Disorder_____
- ☐ ☐ Other _____

_____

PAIN

- ☐ ☐ Acute Pain _____
- ☐ ☐ Chronic Pain _____
- ☐ ☐ Fibromyalgia _____
- ☐ ☐ Other _____

_____

INFECTIOUS

- ☐ ☐ HIV_____
- ☐ ☐ Tuberculosis _____
- ☐ ☐ Hepatitis _____
- ☐ ☐ Other _____

_____

RESPIRATORY

- ☐ ☐ Shortness of Breath _____
- ☐ ☐ Asthma _____
- ☐ ☐ Obstructive Sleep Apnea _____
- ☐ ☐ Pulmonary Hypertension _____
- ☐ ☐ Other Lung Disorders_____

HEMATOLOGY/ONCOLOGY

- ☐ ☐ Bleeding Disorder _____
- ☐ ☐ Cancer (explain) _____

_____

- ☐ ☐ Other _____

_____

OTHER

- ☐ ☐ Substances Abuse (Please check) _____
  - ☐ Marijuana ☐ Cocaine ☐ Methamphetamine
  - ☐ Heroine ☐ Ketamine
- ☐ ☐ Other Recreational Drugs_____
- ☐ ☐ Last Use_____
- ☐ ☐ History assault_____
- ☐ ☐ History of violent behavior_____

_____

- ☐ ☐ Other_____

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Do you exercise regularly?*

How many meals do you eat per day?*

Are you happy with your weight?*

When was the last time you drank alcohol, what type and how much?*

Are you concerned about your alcoholic intake?*

List any non-prescribed and/or illicit drug use*
If none, type "n/a" or "none"

In the last year have you drank alcohol or used drugs more than you meant to?*

Have you wanted/needed to cut down on your drinking or drug use in the last year?*

In the last year have you used alcohol or non-prescription drugs to deal with feelings of frustration or stress?*

As a result of drinking or drug use has anything happened in the last year that you wished hadn't happened?*

Describe the stresses in your life?*

I am not happy with*

- [ ] Myself
- [ ] My Partner
- [ ] My Health
- [ ] My Work
- [ ] My Life History
- [ ] My Suicide Attempt
- [ ] Not Applicable

Please check the boxes related to the following conditions for Depression*

- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Siblings
- [ ] Significant Other
- [ ] Not Applicable

Please check the boxes related to the following conditions for PTSD*

- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Siblings
- [ ] Significant Other
- [ ] Not Applicable

Please check the boxes related to the following conditions for Schizophrenia*

- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Siblings
- [ ] Significant Other
- [ ] Not Applicable

Please check the boxes related to the following conditions for Suicidality*

- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Siblings
- [ ] Significant Other
- [ ] Not Applicable

Please check the boxes related to the following conditions for Drug Abuse*

- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Siblings
- [ ] Significant Other
- [ ] Not Applicable

Please check the boxes related to the following conditions for Alcohol Abuse*

- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Siblings
- [ ] Significant Other
- [ ] Not Applicable

Please add any other pertinent health information below

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Please provide a signature below*

I confirm that, to the best of my knowledge, this document accurately reflects my personal health information.

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FINANCIAL

I understand that New Life Ketamine Clinic, LLC does not accept insurance. Upon request, I will be given a receipt that I may submit to my insurance for possible reimbursement. As well, I understand that if I cancel within 24 hours or do not show up for an appointment, I will be billed the entire amount of the appointment. I have been given the opportunity to ask questions regarding this statement.

Signature | Printed Name | Date

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PRACTICE POLICIES

You will be evaluated by a trained and licensed provider. We wish to take this opportunity to welcome you and to state some basic principles we believe essential in establishing a good relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first history and physical is considered an evaluation interview and exam. At the time of this appointment, the following decisions will be made with you:
   a) If ketamine is an appropriate treatment option
   b) Frequency of ketamine infusion sessions
   c) Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment varies in length depending on your chief complaint. Typically, 40 min infusion appointments take just under 2 hours, 4 hour infusions are typically around 5 hours in length. At the end of each appointment you can make arrangement for your next appointment or you may also book all your prescribed appointments at once.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged for your appointment if not canceled at least 24 hours in advance other than for emergency reasons.

4. PAYMENTS: We would greatly appreciate payment in full prior to the start of your appointment. If you do not have a charge card. We will accept cash or money order. Please make money order out to The New Life Ketamine Clinic, LLC. We do have financing options available to you from a 3rd party company, Advance Care Card on our website.

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how treatment will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you in by giving you receipts to submit to your insurance company. Payments for services received through New Life Ketamine Clinic, LLC are ultimately your responsibility and must be paid prior to treatment.

6. CONFIDENTIALITY: All information regarding the specific nature of your treatment is maintained at The New Life Ketamine Clinic, LLC and is considered confidential within the office unless specified by you in writing. However, each provider at this office reserves the right to use specialty consultation with other medical providers at the office as deemed necessary. We follow HIPAA and maintain confidentiality.

Please check and initial boxes.

◯ Yes ◯ No I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

◯ Yes ◯ No I have received a copy of the Privacy Practices Form.

◯ Yes ◯ No I consent to the exchange of treatment information between The New Life Ketamine Clinic, LLC and my primary care or mental health provider.

Physician's Name/Office and Phone Number:

Signed (Patient):

Date:

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PRACTICE POLICIES – PATIENT COPY TO KEEP

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