KETAMINE CLINIC OF MICHIGAN
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NEW PATIENT HISTORY

Name _____ Date _____

1. Have you been diagnosed with (check all that apply):

   ☐ Depression
   ☐ Major Depressive Disorder
   ☐ Treatment Resistant Depression
   ☐ Bipolar Disorder
   ☐ PTSD (Post Traumatic Stress Disorder)

2. When were you diagnosed? _____

3. Who made the diagnosis and what is their name?

   ☐ Psychiatrist _____
   Name

   ☐ Psychologist _____
   Name

   ☐ Primary Care Doctor _____
   Name

   ☐ Other _____
   Name Phone Number

4. Are you currently under the care, or have you ever been under the care of a psychiatrist?

   ☐ Yes _____ _____
   Name Phone Number
   ☐ No

5. What is the name of your primary care doctor? _____

_____
Name Phone Number

6. Please list any medications you are currently taking, or have tried in the past, to treat depression, bipolar disorder, PTSD, etc.

_____ _____

_____ _____

_____ _____

_____ _____

7. How effectively have these medications worked for you?

- ☐ Not at all
- ☐ Not well
- ☐ Okay
- ☐ Fairly well
- ☐ Very effective

8. Have you ever considered suicide?

- ☐ Yes
- ☐ No

9. Have you ever actually attemmpted suicide?

- ☐ Yes
- ☐ No

10. Have you considered suicide in the past month?

- ☐ Yes
- ☐ No

11. Do you have a history of substance abuse?

- ☐ No
- ☐ Yes
  - ☐ Alcohol
  - ☐ Drugs (list) _____

    _____

    _____

12. Are you curretly taking, or have you recently taken, an MAO inhibitor*
*MAO inhibitors include: isocarboxazid (Marplan), nialamide (Niamid), phenelzine (Nardil, Nardelzine), hydracarbazine, tranylcypromine (Parnate, Jatrosom), rasagiline (Azilect), selegiline (Deprenyl, Eldepryl, Emsam, Zelapar).

    ☐ Yes

    ☐ No

13. Do you have a history of psychosis, schizophrenia, nervous breakdown, or hallucinations?

    ☐ Yes

    ☐ No

14. Do you have poorly controlled high blood pressure?

    ☐ Yes

    ☐ No

15. Do you have angina (chest pain related to a heart problem)?

    ☐ Yes

    ☐ No

16. Have you had a heart attack, heart surgery, or coronary artery stents placed in the past six months?

    ☐ Yes

    ☐ No

17. How did you hear about our clinic?

    ☐ Referred by healthcare professional

    ☐ Internet

    ☐ Word of mouth (friend, relative, coworker, etc.)

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or havng little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult