

Ketamine Screening Questionnaire

Before you are able to receive Ketamine treatment, we need to make sure that it is safe for you to do so. To that end, we need information about the possible factors that could enhance your risk to experience unintentional adverse effects. Please fill out the questionnaire carefully and honestly. This form will subsequently be assessed by a physician.

First and last name: _____

Weight: _____

Screening questionnaire

- | | | |
|--|------------------------------|-----------------------------|
| 1. Do you have a history of problems with anesthesia? | Yes ☐ | No ☐ |
| 2. Have you recently had a cold or the flu? | Yes ☐ | No ☐ |
| 3. Are you allergic to latex (rubber) products? | Yes ☐ | No ☐ |
| 4. Have you experienced chest pain? | Yes ☐ | No ☐ |
| 5. Do you have a heart condition? | Yes ☐ | No ☐ |
| 6. Do you have a history of hypertension or low blood pressure? | Yes ☐ | No ☐ |
| 7. Have you ever had a stroke? | Yes ☐ | No ☐ |
| 8. Have you ever undergone surgery to your head? | Yes ☐ | No ☐ |
| 9. Have you ever had a severe head trauma? | Yes ☐ | No ☐ |
| 10. Have you ever lost consciousness without any known reason? | Yes ☐ | No ☐ |
| 11. Do you have asthma, bronchitis, or any other breathing problem? | Yes ☐ | No ☐ |
| 12. Have you had hepatitis, liver disease, or jaundice? | Yes ☐ | No ☐ |
| 13. Do you have or have you ever had kidney disease? | Yes ☐ | No ☐ |
| 14. Do you have any bleeding problems? | Yes ☐ | No ☐ |
| 15. Have you ever (at present or in the past) suffered from a brain-related, neurological illness? | Yes ☐ | No ☐ |
| 16. Do you suffer from frequent severe headaches? | Yes ☐ | No ☐ |
| 17. Do you have another chronic illness/disorder not yet listed above? | Yes ☐ | No ☐ |
| 18. Are you currently taking antibiotics? | Yes ☐ | No ☐ |
| 19. Do you take any herbals or complementary or alternative medicines? | Yes ☐ | No ☐ |
| 20. Are you taking your medications as prescribed? | Yes ☐ | No ☐ |
| 21. (Women) are you pregnant , or is there a chance that you might be? | Yes ☐ | No ☐ |
| 22. (Men) Do you take Viagra, Cialis, or other erectile dysfunction medicines? | Yes ☐ | No ☐ |
| 23. Does someone in your family have a psychiatric illness/disorder? | Yes ☐ | No ☐ |
| 24. Does someone in your family have schizophrenia or a psychotic illness? | Yes ☐ | No ☐ |
| 25. Do you have sleeping problems such as Obstructive Sleep Apnea? | Yes ☐ | No ☐ |
| 26. Do you experience panic/anxiety attacks? | Yes ☐ | No ☐ |
| 27. Have you ever undergone TMS or Electroconvulsive therapy? | Yes ☐ | No ☐ |
| 28. Do you averagely consume more than 3 alcoholic units a day? | Yes ☐ | No ☐ |
| 29. Have you ever suffered from substance dependence or abuse? | Yes ☐ | No ☐ |



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30. Are you using marijuana presently in the past 2 weeks? Yes ☐ No ☐
31. Have you used any recreational drugs during the past year?
(Such as marijuana, ecstasy, cocaine, etc.) Yes ☐ No ☐
32. Do you experience dissociation, which is a sudden feeling of being detached or
disconnected from reality and your immediate surroundings, often occurring during a time of stress?
Yes ☐ No ☐

Please comment on positive (yes) responses to the previous questions:

I answered all questions to the best of my knowledge and belief:

Signature _____

Date: _____ - _____ - _____



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Treatment History

Evidence of at least four Medications Trials from earliest to latest, including two different agent classes, during this episode.

Medication Class	Med Name	Max Dose	Time Period	Response	Side Effects	Current Med
SSRIs						
SNRIs						
NDRI						
TCAs						
MAOIs						
Other						

List any augmentation strategies tried in the table below:

Strategy	Max Dose	Response	Side Effects	Notes
Lithium				
Thyroid Hormone				
Stimulants				
Dual Anti-Depressants				
Psychotherapy				
ECT				
TMS				

Level of Care	Number of Admissions/Sessions	Date/s	Response
Inpatient			
Residential			
Partial/Day Treatment			
Intensive Outpatient Treatment			
Psychotherapy/Outpatient Counseling			

Other Therapies? Describe date and treatment and effectiveness): _____

