 Matron Health|786 McCool Rd Suite 6. Valparaiso, IN 46385|Ph: 844-457-8503|Fax:844-457-8503

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 qualified health care provider.

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. Do you take any herbals or complementary or alternative medicines? Yes __ No __
19. Are you taking your medications as prescribed? Yes __ No __
20. (Women) are you pregnant, or is there a chance that you might be? Yes __ No __
21. (Men) Do you take Viagra, Cialis, or other erectile dysfunction medicines? Yes __ No __
22. Does someone in your family have a psychiatric illness/disorder? Yes __ No __
23. Does someone in your family have schizophrenia or a psychotic illness? Yes __ No __
24. Do you have sleeping problems such as Obstructive Sleep Apnea? Yes __ No __
25. Do you experience panic/anxiety attacks? Yes __ No __
26. Have you ever undergone TMS or Electroconvulsive therapy? Yes __ No __
27. Do you averagely consume more than 3 alcoholic units a day? Yes __ No __
28. Have you ever suffered from substance dependence or abuse? Yes __ No __
29. Are you using marijuana presently in the past 2 weeks? Yes __ No __
30. Have you used any recreational drugs during the past year? (Such as marijuana, ecstasy, cocaine, etc.) Yes __ No __
31. 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 __

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

_____

_____

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

Signature _____

Date: _____ - _____ - _____