**KAP Screening Pre-Psychiatric Evaluation Questions**

Patient Name                         DOB                  Height:                   Weight:

Age?             (Must be between 18 and 65 years old or with medical clearance)

Name of your primary care physician (required):

last time you were seen:

Contact information and telephone number of your primary care physician:

Do you have a current therapist or psychiatrist? If so, please provide their name, number, and contact information:

List or describe any labels/diagnoses that you currently have or have had for, such as (circle any below or list after last bulleted item)

* Major Depressive Disorder,
* Post-Traumatic Stress Disorder,
* Bipolar Disorder,
* Anxiety or Panic Attacks/Disorders,
* Autism Spectrum Disorder,
* Schizophrenia,
* Schizoaffective Disorder
* List any other current or past psychological or mental/emotional health conditions for which you needed treatment:

Describe or list any treatments, therapy, or hospitalizations that you have had or currently are receiving for any of the above problems or conditions:

List any medications that you have taken or are currently on, the doses, how long have you taken them, and for what reason:

 (If on antipsychotics, Lamictal, benzodiazepines, opiates, stimulants, Calcium channel blockers, or non-prescribed drugs such as marijuana or stimulants, you will need to taper down or off of these or hold doses before ketamine treatment according to the doctor’s recommendations)

Do you have any allergies or past reactions to any medications or Ketamine?

If you are currently pregnant or nursing, it would be a contraindication for ketamine administration or treatment because of potential risk. If there is any possibility that you may be pregnant, you need to do a pregnancy screening test before Ketamine treatment.

Do you have high blood pressure, or are you under current treatment for it?

If so, what medications are you now taking or have taken in the past:

(Well-controlled hypertension may be considered for the KAP program, but uncontrolled hypertension would be a contraindication for ketamine treatment)

List or describe any diagnosis/medical conditions such as (circle any below or list after last bulleted item)

* heart disease, coronary artery disease, history of a heart attack, or unstable angina,
* heart arrhythmia, or congestive heart failure
* history of an aneurysm, a history of a stroke, or increased intracranial pressure
* obstructive sleep apnea or COPD,
* thyroid condition/disorder,
* cystitis or any bladder issues,
* increase intraocular pressure (i.e., glaucoma),
* abnormal liver function tests?
* List any others:

Any history of problems with substance use or disorders as with stimulants (circle any that have been a problem):

* methamphetamines,
* cocaine,
* opioids,
* or alcohol

If you use alcohol, how many drinks per week\_\_\_\_\_?

List any substance problems for which you have had treatment:

Have you used Ketamine or hallucinogens in the past as either a part of a treatment program or recreationally?

When was the approximate date of last ketamine use?

Do you have a friend or family member you can trust who will be able to drive you home from appointments as needed?

What are your expectations for KAP and therapeutic interventions?

   **DAYA MENTAL HEALTH & WELLNESS AUTHORIZATION FOR RELEASE OF INFORMATION FOR COORDINATION OF CARE**

Patient Last Name:

Patient First Name:

D.O.B.

Phone Number:

Address

I authorize medical and/or mental health information to be released and information to be obtained between and shared with Daya Mental Health and Wellness and the following:

To my Primary Care Physician:

Phone:

Address:

To my Therapist:

Phone:

Address

Other provider or family/friend:

Phone:

Address:

I understand that by signing below, I am authorizing the release of all my medical record for the purpose of my treatment and/or pertinent healthcare operations. This release may include records containing information regarding the diagnosis and/or treatment of mental illness, and/or drug and/or alcohol addiction or abuse to any person/persons and/or agency noted above. I also understand that I have the right to revoke this release in writing at any time.

Patient Signature:

Date:

Printed Name: