MIND REJUVENATION

# INITIAL INTAKE

Patient Name _____ DOB _____

Address _____ Phone _____ Cell Home Work

_____ Email _____

Who referred you? _____

## Cultural Consideration Ethnicity Background

Ethnicity: _____ Caucasian _____ Hispanic or Latino _____ African American

_____ American Indian _____ Other _____ _____ Prefer not to answer

Other cultural concerns or preferences: _____

What would you say gives your life meaning or purpose? _____

## Reason for Visit

Who is completing this form? _____ Self _____ Parent/Guardian _____ Other _____

Type of depression? _____ Treatment Resistant Depression _____ Major Depressive Disorder with suicidal ideation

Reason for Visit: _____ Spravato Nasal Spray _____ Ketamine IV Infusion (self-pay only)

## Insurance

**Primary Insurance**

Insurance Name _____ Policy No. _____

Policy Holder _____ Group No. _____

Policy Holder's DOB _____ Social Security No. _____

**Secondary Insurance**

Insurance Name _____ Policy No. _____

Policy Holder _____ Group No. _____

Policy Holder's DOB _____ Social Security No. _____

**Other Insurance**

Insurance Name _____ Policy No. _____

Policy Holder _____ Group No. _____

Policy Holder's DOB _____ Social Security No. _____

## Physician History

**Please list any physicians you see and the reason why you see them**

| Physician | Reason for seeing |
|---|---|
| Referring Provider: | |
| Primary Care: | |
| | |
| | |

## Psychological

History of Depressed Mood: _____ Yes _____ No

History of irritability, anger or violence (tantrums, hurts others, cruelty to animals, destroys property, etc.…)

_____

_____

**Sleep Pattern:** Number of hours per day? _____ Time to onset of sleep? _____

_____ Normal _____ Sleeping too much _____ Sleeping too little

**Ability to Concentrate:** _____ Normal _____ Difficulty concentrating

**Energy Level:** _____ Low _____ Average/Normal _____ High

**INITIAL INTAKE**

## Family & Social Relations

**Current Situation**

_____ Single _____ Married _____ Divorced _____ Never married

**Living Situation**

_____ Alone _____ With spouse _____ With family _____ With significant other _____ Homeless

**Does the client have children?**

| Name | Age | DOB | Sex | Custody Y/N | Additional Information |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Who lives in the home?**

| Name | Age | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Perceived level of support for treatment? (scale 1-5 with 5 being the most supportive) _____

Primary support person/system? _____

**Leisure & Recreation**

Which of the following does the client do? (Select all that apply)

| Leisure | Y/N | How often weekly | Leisure | Y/N | How Often weekly |
|---|---|---|---|---|---|
| Spend time with friends | | | Sports / Exercise | | |
| Classes | | | Dancing | | |
| Spend time with family | | | Hobbies | | |
| Work part-time | | | Watch movies / TV | | |
| Go "Downtown" | | | Stay at home | | |
| Listen to music | | | Spend time at clubs/bars | | |
| Go to Casinos | | | Other: | | |
| What limits the client's leisure/recreational activities? | | | | | |

## Self-Harm Behaviors History

**Have you ever intentionally harmed yourself with or without suicidal thinking?** _____ Yes _____ No

**Have you ever attempted suicide?** _____ Yes _____ No

If yes, when? _____

**Do you consider yourself a high risk to attempt suicide in the near future?** _____ Yes _____ No

**Have you ever considered or thought about suicide?** _____ Yes _____ No

If yes, when? _____

**Have you ever attempted to harm someone other than yourself?** _____ Yes _____ No

**Have you ever considered hurting someone else?** _____ Yes _____ No

**Are you dealing with any of these thoughts currently?** _____ Yes _____ No

**INITIAL INTAKE**

## Substance Abuse

| Substance | Age of first use | Current weekly use |
|---|---|---|
| Alcohol | | |
| Sedatives (anxiety & sleep meds, benzodiazepines, barbiturates, soma, Fioricet, etc.) | | |
| Pain meds (opiates, prescription pain meds, heroin) | | |
| Marijuana (inc. synthetic cannabinoids) | | |
| Stimulants (Prescription, Methamphetamine, Cocaine, etc.) | | |
| Hallucinogens (LSD, PCP, mushrooms, peyote, DMT, 2C-B, salvia, etc.) | | |
| Club drugs (GHB, Ketamine, Methoxetamine, etc.) | | |
| Inhalants (glue, spray paint, nitrous oxide, amyl nitrate, "poppers", etc.) | | |
| Steroids | | |
| Caffeine | | |
| Tobacco | | |
| Others (Kratom, Ibogaine, etc.) | | |

Ever injected drugs? _____ Yes _____ No Which ones? _____

Drug of choice? _____

**Consequences as a result of drug/alcohol use (select all that apply)**

_____ Hangovers _____ DTs/Shakes _____ GI Bleeding _____ Liver Disease

_____ Overdoses _____ Seizures _____ Assaults _____ Left School

_____ Sleep Problems _____ DUIs _____ Binges _____ Relationship Problems

_____ Lost Job _____ Homicide _____ Arrests _____ Increased Tolerance-need more for a high

_____ Incarcerations _____ Blackouts _____ Other: _____

Longest period of sobriety? _____ How long ago? _____

Triggers to use (list all that apply): _____

## Past Medical Health Treatment

Have you been diagnosed with mental health issues in the past? _____ Yes _____ No

If yes, what diagnosis have you had? _____

At what age were you first evaluated and/or treated for this? _____

Have you been treated for mental health issues with medications? _____ Yes _____ No

**Have you had any of the following alternative treatments for mental health symptoms?**

_____ ECT _____ Transcranial Stimulation Vagal Nerve Stimulator _____ Psychotherapy

_____ Other _____

**Have you ever seen a therapist for mental health symptoms?** _____ Yes _____ No

If yes, please provide the approximate date and name of provider _____

**Have you ever been hospitalized for mental health reasons?** _____ Yes _____ No

If yes, please list the approximate date, facility, and reason for admission _____

## Nutrition

**Nutritional Status:** Current Weight _____ Current Height _____ BMI _____

**Appetite:** _____ Good _____ Fair _____ Poor, Please explain below

_____ Recently ____ **gained/**_____**lost** significant weight

**INITIAL INTAKE**

## Allergies

**Please list all known allergies:** _____

## Review of Medical History

**Please elaborate on any condition you have.**

| Allergy | General | ENT |
|---|---|---|
| Runny Nose | Weight Gain | Cold |
| Scratchy Throat | Weakness | Cough |
| Itchy Eyes | Loss of Appetite | Nose Bleeds |
| Sneezing | Fever | Hearing Loss |
| Ear Fullness | Breastfeeding | Change in Voice |
| Sinus Congestion | | Sore Throat |
| Sinus Drainage | | Ringing in Ears |
| Itchy Nose | | Sinus Pain/Headaches |
| **Respiratory** | **Endocrinology** | **Cardiology** |
| Chest Pain | Fatigue | Dizziness |
| Cough | Excessive Thirst | Chest Pain |
| Wheezing | Weight Loss | Palpitations |
| Shortness of Breath | Sleep Disturbance | Rapid Heart Rate |
| Chest Congestion | Cold Intolerance | High Blood Pressure |
| Dyspnea | Heat Intolerance | Low Blood Pressure |
| Sleep Disturbance | Diabetes | Leg Edema |
| Difficult to breath ly | Thyroid Disorder | Leg Pain |
| **Gastroenterology** | **Urology** | **Neurology** |
| Nausea | Recurring UTI | Headache |
| Heartburn | Blood in Urine | Seizures |
| Hemorrhoids | Difficult Urinating | Insomnia |
| Vomiting | Frequent Urination | Tic/Twitching |
| Blood in Stool | Nocturia | Memory Change |
| Diarrhea | Ulcerative/Interstitial Cystitis | Tingling/ Numbness |
| Abdominal Pain | | Dizziness |
| Constipation | | |
| Hematology | Psychology | Other |
| History of Anemia | Depression | Aneurysmal Vascular Disease or Arteriovenous Malformation ***including Thoracic or abdominal aorta, intracranial & peripheral arterial vessels |
| Swollen Glands | Anxiety | |
| Easy Bruising | High Stress | |
| Other: | Sleep Disturbance | |
| | Suicidal Thoughts | |
| | Substance Abuse | Hypersensitivity to Ketamine, Ketamine or any other excipients |
| | Eating Disorder | |
| | Agitation/Irritable | |
| | | Intracerebral Hemorrhage |