TEMENOS Center for Integrative Psychotherapy
Ketamine-Assisted Psychotherapy

MEDICAL AND PSYCHOLOGICAL INTAKE FORM

Please complete this questionnaire as thoroughly as possible. It is very important to accurately share information that could influence your treatment. Please use additional sheets if necessary to explain all answers. Write "N.A." if an item doesn't apply so we know you didn't miss it. We will review this material during your intake appointment.

This is a confidential record.

NAME ____

MEDICAL INFORMATION / HISTORY

Current Height & Weight	
Significant Past or Current Medical Diagnoses	
Major Surgeries (with dates). Any adverse reactions to anesthesia?	
Hospitalizations (include reasons & dates)	
Major Physical Traumas (explain with dates)	
When was the last time that you were seen for a medical check-up?	
Have you ever been diagnosed with any kind of heart disease or abnormal heart function? Have you ever had an EKG?	
Have you been diagnosed with hyper- or hypothyroidism?	
Have you been diagnosed with, or are you being treated for high blood pressure?	
Do you wear a Medic Alert tag? If so, what does it say?	
What else do we need to know about your current health or your health history?	

Considering your age, how would you describe your overall health? □ Excellent □ Good □ Fair □ Poor
In general, how would you rate your energy level on a scale of 0 - 10?

Do you have chronic and/or debilitating pain anywhere in your body?
How many times a week do you exercise? ______________ Are you satisfied with your level of fitness? Y ☐ N ☐ What physical activities do you enjoy doing or are you interested in?
Average number of hours of sleep per night? Do you have any trouble falling asleep, or waking and going back to sleep? Do you feel rested after sleeping?
Describe your diet and any food issues.
Do you use tobacco? Amount.
Do you use caffeine? Amount.

ALLERGIES

Please list all of your allergies, including foods, medications, fragrances, environmental and the nature of the reaction, if known.

MEDICATIONS

Please list all medications you take and include: prescriptions, herbs, supplements, and as-needed meds. Please include EVERYTHING that you have taken within the past six months and any psychiatric medications over the course of your life.

MEDICAL CONDITIONS

Check any which you have experienced in the last three months.

	GENERAL		GASTRO-INTESTINAL		CARDIOVASCULAR
	Fatigue		Nausea		Low blood pressure
	Excessive thirst		Hemorrhoids		High blood pressure
	Sudden energy drops		Black stools		Cold hands or feet
	Night sweats		Bloating		Chest pain
	Intolerance to heat/cold		Rectal Pain		Palpitations
	Slow metabolism		Constipation		Irregular heartbeat
	Chills		Blood in stools		Fainting
	Fevers		Mucous in stools		Other
	Other		Gas		**URINARY**
	NEUROLOGICAL		Abdominal Pain		Urinary urgency
	Seizures		Difficulty swallowing		Painful urination
	Poor sleep		Heartburn		Blood in urine
	Lack of coordination		Indigestion		Incontinence
	Difficulty concentrating		Vomitting		Kidney stones
	Active dreaming		Diarrhea		Irregular flow
	Irritabiity		Poor appetite		Frequent urination
	Poor memory		Food cravings		Decreased flow
	Loss of balance		Food allergies		Other
	Headaches		Other		**MISC.**
	Migraines				Any childhood illnesses?
	Numbness				Any problems with your birth?
	Hours of sleep: _______				Other
	Other				

	HEAD, EYES, EARS, NOSE & THROAT		RESPIRATORY		FAMILY HISTORY Immediate Family Parents/Grandparents Siblings/Children
	Headaches		Cough		Cancer (explain)
	Cold sores		Asthma		Heart disease
	Cataracts		Bronchitis		Mental health issues
	Clicking jaw		Difficulty breathing when lying down		High blood pressure
	Nosebleeds		Shortness of breath without exertion		Neurological disease
	Poor vision		Production of phlegm		Thyroid disease
	Facial pain		Frequent colds & flus		Auto-immune
	Blurred vision		Pneumonia		Diabetes
	Mucous in throat		Other		Trauma
	Frequents colds		**SKIN & HAIR**		Alcohol/substance abuse
	Earaches		Rashes		Other
	Ear infections		Eczema		**BIOLOGICAL FEMALE ISSUES**
	Poor hearing		Itching		Age at first menses: ____________
	Ringing in ears / tinnitus		Hair loss		Date last menstrual cycle: __________
	Sinus congestion		Hives		Length of cycle ___________________
	Sore throat		Pimples/acne		Duration of bleeding: ______________
	Dizziness		Poor healing		Heavy or unusual bleeding / clots
	Grinding teeth		**PREGNANCY**		Pain with intercourse
	Other		# of pregnancies _________		Discharges
			# of live births ___________		Irregular cycles
			# of miscarriages ________		Cramps / PMS
			# of abortions ___________		Onset of menopause: _____________
			Birth control? ____________		Other

PSYCHOLOGICAL HEALTH

Briefly describe your current reasons for seeking treatment. What do you hope to gain? When did these problem(s) / issue(s) begin? What seems to help? What makes it/them worse?
In general, how satisfied are you with your life? □ Very satisfied □ Mostly satisfied □ Somewhat disappointed □ Mostly disappointed
Do you have difficulties with depression and/or anxiety? Please describe.
Have you ever experienced a dissociative trauma? Please describe.
Do you have, or have you ever had, post-traumatic stress disorder (PTSD)? Please describe.
Do you have obsessive-compulsive disorder (OCD)? Please describe.
Have you ever experienced any form of psychosis (e.g., hallucinations, delusions, paranoia) when not under the influence of a psychoactive substance?
Does any member of your family have psychological problems, mental illness and/or problems with substance abuse?
If you are currently in psychotherapy, list frequency, type, and length of treatment.
Does your current therapist know that you are applying for ketamine-assisted psychotherapy?
Have you had any psychotherapy (individual, couple, group, or child) and/or psychiatric services **in the past**? Please describe.

How would you rate your general stress level on a scale of 0 - 10? What are your major sources of stress? How do you manage stress?
What kind of support systems do you have in your life?
Do you have any history or trauma or abuse (childhood, adulthood, intergenerational)? Describe.
What are your current wellness practices?
What else do we need to know about your psychological health or history?

PSYCHOLOGICAL CONDITIONS / EXPERIENCES

Check any that you have experienced at any time in your life.

	Depression		Bipolar disorder		Physical or sexual abuse
	Anxiety		Obsessive/compulsive disorder		Rape / sexual assault
	Panic attacks		Slurred or rapid speech		Domestic violence
	High stress levels		Unexplained memory lapses		Crying spells
	Difficulty concentrating		Alcohol abuse		Recurrent nightmares
	Irritability / Fearfulness		Substance abuse		Social anxiety
	Phobias		Eating disorder		Financial stress
	Sleep disturbances/tiredness		Self harm / self mutilation		Work-related stress
	Post traumatic stress		Body image issues		Relationship stress
	Poor memory		Changes in appetite / unexplained weight loss or gain		Unable to have fun
	Unexplained losses of time		Psychiatric hospitalization(s)		Anger management
	Suicidal ideation		Lacking confidence		Lonely / unable to make or keep friends
	Suicidal attempt(s) - current?		Feelings easily hurt		Loss of sexual interest

PSYCHOACTIVE SUBSTANCES

Do you have any experience with any of the following substances?
Rate the amount of your experience from 1 - 10. Put 0 if none.

Substance	Rating
Benzodiazapines (e.g. Xanax, Ativan, Klonopin, Valium, Rohypnol)	
Cannabis (marijuana, pot, hash)	
Cocaine (coke, crack)	
Dissociative anesthetics OTHER than ketamine (MXE, PCP)	
DMT (ayahuasca, 5-MeO-DMT, harmaline)	
DXM (dextromethorphan, cough syrup)	
GHB (roofies)	
MDMA (Ecstasy, Molly)	
Ibogaine	
Inhalants (nitrous oxide, glue, gas, paint thinner)	
Ketamine	
LSD	
Mescaline (peyote, san pedro)	
Methamphetamine (speed, crystal meth, ice)	
Opiates and opioids (e.g. heroin, Fentanyl, Oxycodone, Oxycontin, Percocet, Vicodin, methadone, buprenorphine)	
Prescription stimulants (e.g. Ritalin, Concerta, Dexedrine, Adderall)	
Psilocybin (mushrooms)	
Salvia Divinorum	
Steroids	
Other - please specify	

In the past 6 months, on average, how many times per week do you consume alcohol?
In the past 6 months, on average, how many times per week do you use cannabis?
In the past 6 months, how many times total have you used a psychoactive substance other than alcohol or cannabis?
Have you ever had a problem with alcohol and/or drug use? Please describe.

RETURN FORM

Please complete this form, and either send it back to us at:
Temenos Center for Integrative Psychotherapy
1 Bodega Avenue, Suite 4
Petaluma, CA 94952

Or email to us at: info@temenos.center

FINAL STEPS

1. Confirm your Initial Session day and time.
2. Remember that we have a one-week cancellation policy. See Informed Consent form for details.
3. Please contact us with any questions or concerns at 707-992-5015

THANK YOU

We look forward to working with you.