PATIENT REGISTRATION FORM

Golden Life
Ketamine Pain & Depression Clinic

General Information

First Name, MI, Last Name

Date of Birth (mm/dd/yyyy)	**Phone**	**E-mail**

Address

City, State, Zip

Diagnosis (When diagnosed?)

Depression	**Anxiety**	**Bipolar disorder**	**PTSD**
☐	☐	☐	☐

Mental Health Provider

Provider	Name/Address
Psychiatrist	
Psychologist	
Family medicine/Internist	
Other	

Medications (Psychiatric)

Medication	Use	Dosage	Frequency

Medications (Non-Psychiatric)

Medication	Use	Dosage	Frequency

Allergies

Allergy	Reaction

Female Patients Only

Are you pregnant?	Last menstrual period?	Are you breastfeeding?
Yes ☐ No ☐		Yes ☐ No ☐

Medical History

Psychiatric Conditions

☐ Schizophrenia ☐ OCD ☐ Personality disorder ☐ Other

Cardiovascular Conditions

☐ High Blood Pressure ☐ Heart disease ☐ Irregular heart rhythm ☐ Heart attack (within 6 months)
☐ Heart Surgery (within 12 months) ☐ Chest pain ☐ Congestive heart failure (CHF) ☐ Other

Respiratory Conditions

☐ Asthma ☐ COPD ☐ Obstructive sleep apnea (CPAP use) ☐ Other

Neurologic Conditions

☐ Epilepsy (last seizure episode) ☐ Stroke (within 6 months) ☐ Unsteady gait ☐ Dizziness/Fainting
☐ Numbness ☐ Other

GI Conditions

☐ Acid reflux ☐ Nausea/vomiting ☐ Abdominal pain ☐ Liver disorders

Other Conditions

☐ Kidney problems ☐ Chronic pain ☐ Abnormal bleeding/Clotting disorders ☐ Anemia
☐ GYN issues ☐ Muscle/Bone/Joint disorders ☐ Diabetes (Insulin use) ☐ Immune system disorders

Other

Tobacco
Yes ☐ No ☐
Packs per day:

Alcohol
Yes ☐ No ☐
Frequency:

Illicit drugs
Yes ☐ No ☐
Please list:

Substance abuse treatment
Yes ☐ No ☐
When?

Suicide attempts?
Yes ☐ No ☐

Electroconvulsive Therapy (ECT)?
Yes ☐ No ☐

☐ *By submitting this form, I certify that I have completed this questionnaire to the best of my ability.*

☐ *I agree to seek immediate help should my symptoms worsen or I experience an increase in suicidal thoughts, feelings, or urges.*

☐ *I authorize a representative from Golden Life to contact me to discuss treatment options for my condition(s). I also understand that the staff of Minnesota Ketamine Clinic will not start and maintain any prescribed treatment regimen if I am not currently under the care of a Mental Health Professional and maintain such care until the completion of my course of treatment*

Patient's Signature

Date (mm/dd/yyyy)