OPTIMUM
KETAMINE CENTER

Patient Information Questionnaire

Please fax or email your completed questionnaire

Fax: 708-393-4099 **Email**: admin@optketamine.com

First Name	
Last Name	
Home Address	
Home Phone	Mobile Phone

Emergency Contact #1:_____ Emergency Contact #2:_____

Relationship:_____ Relationship:_____

Phone Number:_____ Phone Number_____

Occupation	
Email Address	
Date of Birth (MM/DD/YYYY)	Gender
Preferred contact method:	
Whom can we thank for your referral?	

Optimum Ketamine Center
665 W. North Ave, #101
Lombard, IL 60148
708-244-8663

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For what diagnosis or condition are you seeking Ketamine for?	
How long have you had this condition?	
Have you had treatment for this condition? If yes, please tell us what treatments you have tried.	
Are you currently or have you in the past experienced suicidal ideation?	
Have you ever been treated for any psychiatric conditions not mentioned above? What is that diagnosis?	
Do you have a history of seizures? Are you being treated?	
Do you have high blood pressure? Are you being treated?	
Are you currently taking narcotic medications? Please note, we screen all of our patients.	
Are you pregnant or breastfeeding?	
Do you smoke? If yes, how much?	
Do you drink alcohol? If yes, how much?	
Do you have any history of illicit drug use?	
Do you have any allergies to medications? Please list them.	

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Please provide a list of all of your medications: name, dose, and frequency:

Name	Dose	Frequency

Treating Physician's Information:

Name of physician	Address	Phone Number	Fax Number
Name of physician	Address	Phone Number	Fax Number

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