LORI CALABRESE, MD **INNOVATIVE PSYCHIATRY**
1330 Sullivan Avenue Tel 860.648.9755
South Windsor, CT 06074-2741 Fax 860.648.9756

IV KETAMINE INFUSION THERAPY
NEW PATIENT HISTORY

Name _____ Date of Birth _____

Phone # for Private Calls _____

Address _____

Referring Clinician Name _____

Referring Clinician Phone # _____

Primary Care Physician Name _____

Primary Care Physician Phone # _____

Psychiatrist if different from above _____

Psychiatrist Phone # _____

Therapist if different from above _____

Therapist Phone # _____

How did you hear about our IV Ketamine Infusion Therapy?

_____

Principal Psychiatric Diagnosis _____

Additional Psychiatric Diagnoses _____

_____

How long have you had depression? _____

_____

CONFIDENTIAL

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What are your current symptoms? Please check all that apply

☐	Depressed Mood	☐	Excessive Guilt	☐	Distractibility
☐	Loss of Interest in Things	☐	Poor Concentration	☐	Recklessness
☐	Loss of Motivation	☐	Appetite Change	☐	Increased Self Esteem
☐	Poor Self Esteem	☐	Weight Loss/Gain	☐	Grandiosity
☐	Feelings of Worthlessness	☐	Change in sex drive	☐	Fast thoughts
☐	Insomnia	☐	Sexual indiscretions	☐	Increased talkativeness
☐	Excessive Sleep	☐	Suicidal thoughts	☐	Increased spending
☐	Poor Energy	☐	Suicide attempts	☐	Disorganized thinking

Has your motivation and desire to accomplish things changed? How?

Has depression caused you to miss work or to be entirely unable to work? How? When? Which job or career?

Has depression caused you to perform at less than your best? How? When?

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Do you still enjoy performing the same activities that you used to be involved in the past? (Name the activities.)

Do you feel your relationships with your family and friends have been affected by your depression? How?

Do you have days when you neglect your basic personal needs (e.g., hygiene, skipping meals, unhealthy eating). How?

How long has this current episode lasted? _____

Do you have thoughts of suicide or have you had them in the past? Please describe the frequency and intensity of these thoughts and what you think about. How often do these thoughts occur?

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Have you made a suicide attempt? If so, please describe what happened.

Do you have a history of cutting yourself or injuring yourself in any way? If so, please describe this.

Have you been psychiatrically hospitalized? If so, list hospital(s), reason for the hospitalization(s), approximate date(s) and if the hospitalization was helpful.

How long have you seen your current psychiatrist? _____

How long have you seen your current therapist? _____

What are the most helpful aspects of your current treatment?

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What prompted you to seek IV Ketamine Infusion Therapy with Dr. Calabrese?

Current Psychiatric Medications	Dose	Frequency

Previous Psychiatric Medications	Dose	Duration	Reason Discontinued

Other Current Medications	Dose	Frequency

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Supplement / Over the Counter Medication(s)

Allergies to Medication(s) Reaction

Past Medical History/Medical Problems

Height _____

Weight _____

For women, when was your last menstrual period? _____

Are you currently pregnant, breastfeeding or planning pregnancy? _____

Do you have high blood pressure? _____

If so, what medication are you taking to control it? _____

Do you have a history of seizures or a seizure disorder? _____

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Past Surgical History

Have you had an adverse reaction to anesthesia? If so, describe. _____

Is there a family history of serious or adverse reactions to anesthesia? _____

Have you been to the ER (emergency room) within the past 6 months? If so, please describe the reason for your visit.

Substance Use History

	Qty/Frequency	How many years	Last Use
Tobacco			
Alcohol			
Marijuana			
Cocaine			
Opiates			
Other			

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Family History of Psychiatric Disorders (list family members below)

Suicide Attempts _____
Psychiatric Hospitalization _____
Depression _____
Bipolar Disorder _____
Generalized Anxiety _____
Panic Disorder _____
OCD _____
PTSD _____
Alcohol _____
Other substance use _____

I certify that I have completed this history to the best of my knowledge and ability.

_____ _____
Signature Date

_____
Printed Name