



PHONE :1.310.514.2300
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1366 W 7TH STREET, SAN PEDRO, CA 90732
COASTWISECOUNSELINGCENTER.COM

Ketamine Assisted Psychotherapy Confidential Client Information

Welcome to our practice. We want to make the most of each appointment you have with us. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely as possible. This information is confidential.

1. Name: _____

2. Address:

Street/PO box _____

3. City: _____ State: _____ Zip/Postal Code: _____

4. Home Phone: _____ Cell Phone: _____ Work: _____

May I leave a message? _____

Email: _____

5. SS#: _____

6. Age: _____ Birth date: _____ Gender: _____ Do you identify as transgender? _____

7. Education (grade/degree completed, any post secondary): _____

8. Current Occupation: _____

9. Person to alert in the event of a medical emergency: _____

Address: _____

Relationship to you: _____ Phone: _____

10. Family Doctor: _____ Phone: _____

11. Relationship status (circle one): Single Married Partnered Separated Divorced Widowed If not married, are you currently in a relationship? Yes No If yes, for how long?

12. Spouse's/partner's name: _____ Phone: _____

13. Children (gender, age): _____



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PRIMARY INSURANCE:

Company Name: _____ Ins. ID# _____
Group Name: _____ Group # _____ Employer: _____
Subscriber's Name: _____ Relation: _____ Subscriber's DOB: _____

I certify to the best of my knowledge that all information provided is true and correct.

Name _____ Date: _____

Signature:

14. ALLERGIES:

15. Current Medications—Dose, Frequency, Date Last Taken

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Recreational Drugs—Method, Frequency, Total # of Experiences, Last Date Used



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16. Medical Illnesses, Current and Past:

17. Have you had previous psychological care or counseling? Yes/No

If yes, please give the name of the clinician(s), the dates you saw them (e.g. Nov 2017), and the nature of the difficulty at that time.

18. Have you been prescribed psychiatric medications in the past (e.g. antidepressants, antipsychotics, mood stabilizers, stimulants, tranquilizers)? If so, list each one with dose and describe their effects.

19. Have you ever been hospitalized for a psychological difficulty? Yes No

Have you ever had feelings or thoughts that you didn't want to live? Yes No

If YES, please answer the following. If NO, please skip to question 20 (on next page). Do you currently feel that you don't want to live? Yes

No

How often do you have these thoughts?

When was the last time you had thoughts of dying?



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Has anything happened recently to make you feel this way?

On a scale of 1 to 10 (ten being strongest), how strong is your desire to kill yourself currently?

Would anything make it better?

Have you ever thought about how you would kill yourself?

Is the method you would use readily available?

Have you planned a time for this?

Is there anything that would stop you from killing yourself?

Do you feel hopeless and /or worthless?

Have you ever tried to kill or harm yourself before?

20. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory

Do you have:

-Difficulty falling asleep? Yes No

- Awakenings during the night? Yes No -Poor or unrefreshing sleep? Yes No



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If so, for how long have you been experiencing this problem(s)?

21. Current Weight _____ Height _____ Are you happy with your weight?
_____ Have you recently lost or gained weight? Yes No

Please describe any difficulties you experience with your appetite or eating patterns:

22. Are you currently experiencing overwhelming sadness, grief, or depression? Please circle. If yes, for how long? _____

23. Are you currently experiencing anxiety, or panic attacks? Yes No

If yes, for how long? _____

24. How many days per week do you drink alcohol? _____

How many drinks per night? _____

How often do you binge drink (4-5 drinks within a couple hours)? _____

25. How often do you use recreational drugs? _____

26. Have you ever had a dependency on alcohol or recreational drugs? Yes No

If yes, please explain the nature of dependency or abuse:

If yes, which drug? Please explain the nature of dependency or abuse:



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27. Have you ever or do you now have a history of prescription drug dependency or abuse? Yes No

28. Females: Are you or could you be pregnant? _____

If applicable, what form of BC do you use? _____

29. Has anyone in your family been diagnosed with or treated for:

Bipolar disorder Yes No Schizophrenia Yes No Depression Yes No PTSD Yes No Anxiety Yes No Alcohol abuse Yes No Other substance abuse Yes No Anger issues Yes No Suicide Yes No Violence Yes No

If yes, who had what problems?

Has any family member been treated with a psychiatric medication? Yes No

If yes, who was treated, what medications, and how effective was the treatment?



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30. In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish. What do you consider some of your strengths? Weaknesses?

31. Please list with dates any significant trauma you have experienced: violence—physical, sexual, emotional; abuse; natural occurrences; etc.
