

**LORI CALABRESE, MD**

1330 Sullivan Avenue  
South Windsor, CT 06074-2741

**INNOVATIVE PSYCHIATRY**

Tel 860.648.9755  
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? \_\_\_\_\_

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What are your current symptoms? Please check all that apply

|                                                     |                                               |                                                  |
|-----------------------------------------------------|-----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Depressed Mood             | <input type="checkbox"/> Excessive Guilt      | <input type="checkbox"/> Distractibility         |
| <input type="checkbox"/> Loss of Interest in Things | <input type="checkbox"/> Poor Concentration   | <input type="checkbox"/> Recklessness            |
| <input type="checkbox"/> Loss of Motivation         | <input type="checkbox"/> Appetite Change      | <input type="checkbox"/> Increased Self Esteem   |
| <input type="checkbox"/> Poor Self Esteem           | <input type="checkbox"/> Weight Loss/Gain     | <input type="checkbox"/> Grandiosity             |
| <input type="checkbox"/> Feelings of Worthlessness  | <input type="checkbox"/> Change in sex drive  | <input type="checkbox"/> Fast thoughts           |
| <input type="checkbox"/> Insomnia                   | <input type="checkbox"/> Sexual indiscretions | <input type="checkbox"/> Increased talkativeness |
| <input type="checkbox"/> Excessive Sleep            | <input type="checkbox"/> Suicidal thoughts    | <input type="checkbox"/> Increased spending      |
| <input type="checkbox"/> Poor Energy                | <input type="checkbox"/> Suicide attempts     | <input type="checkbox"/> 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**

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
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**Previous Psychiatric Medications****Dose****Duration****Reason Discontinued**

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**Other Current Medications****Dose****Frequency**

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**Supplement / Over the Counter Medication(s)**

|  |  |
|--|--|
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**Allergies to Medication(s)****Reaction**

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|  |  |

**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

\_\_\_\_\_  
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