Mind Rejuvenation, LLC

Iftikhar Hussain, MD | Mical Pacheco, MSN, APRN, PMHNP-BC

INITIAL INTAKE

Patient Name _____ DOB _____

Address _____ Gender: ☐ Male ☐ Female ☐ Other

City _____ State _____ Zip _____ Who referred you? _____

Phone: _____ ☐ Cell ☐ Home ☐ Work Phone: _____ ☐ Cell ☐ Home ☐ Work

Cultural Consideration Ethnicity Background

Ethnicity: ☐ Caucasian ☐ Hispanic or Latino ☐ African American

☐ American Indian ☐ Other _____ ☐ Prefer not to answer

Other cultural concerns or preferences: _____

What would you say gives your life meaning or purpose? _____

Insurance

Primary Insurance

Insurance Name _____ Policy No. _____

Policy Holder _____ Group No. _____

Policy Holder's DOB _____ Social Security No. _____

Secondary Insurance

Insurance Name _____ Policy No. _____

Policy Holder _____ Group No. _____

Policy Holder's DOB _____ Social Security No. _____

Other Insurance

Insurance Name _____ Policy No. _____

Policy Holder _____ Group No. _____

Policy Holder's DOB _____ Social Security No. _____

Physician History

*** * * * IMPORTANT * * * ***

PHARMACY

Name _____ Phone _____

Address _____

Reason for Visit

Reason for Visit: ☐ Medication Management ☐ ADHD ☐ Spravato ☐ Ketamine

☐ PTSD ☐ OCD ☐ Bipolar ☐ Other: _____

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Medical Information - Past & Present

Have you been diagnosed with mental health issues in the past? ☐ Yes ☐ No

Diagnosis	What age?	Medication Treated? Y/N	Hospitalized? List Date	List family members with same history
Depression		☐		
Bipolar		☐		
Anxiety		☐		
ADHD		☐		
ADHD/attention		☐		
OCD		☐		
Memory issues		☐		
Schizophrenia		☐		
Tourette's disease / Tics		☐		
Hearing / seeing things		☐		
Eating issues		☐		
Substance issues		☐		
Loss/death of significant person		☐		
Victim - Physical abuse		☐		
Victim - Emotional abuse		☐		
Victim - Sexual abuse		☐		
Intellectual disability		☐		
Abnormal thoughts / perceptions		☐		
Antisocial behavior/arrests/incarceration		☐		
Other:		☐		
Other:		☐		
List any ADDITIONAL diagnosis NOT pertaining to mental health	**What age?**	**Medication Treated? Y/N**	**Hospitalized? List Date**	**List family members with same history**
		☐		
		☐		
		☐		
		☐		
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		☐		

INITIAL INTAKE

Psychological

History of: ☐ Depressed mood ☐ Irritability ☐ Anger ☐ Violence

Violent History: ☐ Tantrums ☐ Hurt others ☐ Cruelty to animals ☐ Destroys property

Other: _____

Other: _____

Sleep Pattern: Number of hours per day? _____ Time to onset of sleep? _____

☐ Normal ☐ Sleeping too much ☐ Sleeping too little

Ability to Concentrate: ☐ Normal ☐ Difficulty concentrating

Energy Level: ☐ Low ☐ Average/Normal ☐ High

Self-Harm Behaviors History

Have you ever intentionally harmed yourself with or without suicidal thinking? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, when? _____

Do you consider yourself a high risk to attempt suicide in the near future? ☐ Yes ☐ No

Have you ever considered or thought about suicide? ☐ Yes ☐ No

If yes, when? _____

Have you ever attempted to harm someone other than yourself? ☐ Yes ☐ No

Have you ever considered hurting someone else? ☐ Yes ☐ No

Are you dealing with any of these thoughts currently? ☐ Yes ☐ No

Addictive Behaviors

Gambling Addiction? ☐ Yes ☐ No

At what age behavior began? _____ How often do you gamble? _____

How much money spent in the last month? _____ Last 6 months? _____

Problematic / disordered eating (e.g., overeating, undereating, atypical eating)

Have you or others expressed concerns about your eating patterns? ☐ Yes ☐ No

Have you had any previous treatment for eating disorder symptoms? ☐ Yes ☐ No

If yes, please give details

_____

Problematic / disordered eating (e.g., overeating, undereating, atypical eating)

Have you or others expressed concerns about your eating patterns? ☐ Yes ☐ No

If yes, age this was first noticed? _____

Excessive Exercise? ☐ Yes ☐ No If yes, what age problem behavior began? _____

How much time is spent weekly in exercise? _____

Please note which of the areas above have contributed to problems or conflict in your life. _____

_____

Addictive Behaviors (Cont.…)

Sexual Behavior Addiction? ☐ Yes ☐ No If yes, what age problem behavior began? _____

Internet Addiction? ☐ Yes ☐ No If yes, what age problem behavior began? _____

Substance Use

Substance	Age first use	Current weekly use
Alcohol		
Sedatives (anxiety & sleep meds, benzodiazepines, barbiturates, soma, Fioricet, etc.)		
Pain meds (opiates, prescription pain meds, heroin)		
Marijuana (inc. synthetic cannabinoids)		
Stimulants (Prescription, Methamphetamine, Cocaine, etc.)		
Hallucinogens (LSD, PCP, mushrooms, peyote, DMT, 2C-B, salvia, etc.)		
Club drugs (GHB, Ketamine, Methoxetamine, etc.)		
Inhalants (glue, spray paint, nitrous oxide, amyl nitrate, "poppers", etc.)		
Steroids		
Caffeine		
Tobacco		
Others (Kratom, Ibogaine, etc.)		

Ever injected drugs? ☐ Yes ☐ No Which ones? _____

Drug of choice? _____

Consequences as a result of drug/alcohol use (select all that apply)

☐ Hangovers	☐ DTs/Shakes	☐ GI Bleeding	☐ Liver Disease
☐ Overdoses	☐ Seizures	☐ Assaults	☐ Left School
☐ Sleep Problems	☐ DUIs	☐ Binges	☐ Relationship Problems
☐ Lost Job	☐ Homicide	☐ Arrests	☐ Increased Tolerance-need more for a high
☐ Incarcerations	☐ Blackouts	☐ Other: _____	

Longest period of sobriety? _____ How long ago? _____

Triggers to use (list all that apply):

Please list all known allergies:

INITIAL INTAKE

Family & Social Relations

Current Situation

☐ Single ☐ Married ☐ Divorced ☐ Never married

Living Situation

☐ Alone ☐ With spouse ☐ With family ☐ With significant other ☐ Homeless

Does the client have children?

Name	Age	DOB	Sex	Custody Y/N	Additional Information

Who lives in the home?

Name	Age	Relationship

Perceived level of support for treatment? (scale 1-5 with 5 being the most supportive) _____

Primary support person/system? _____

Leisure & Recreation

Which of the following does the client do? (Select all that apply)

Leisure	Y/N	How often weekly	Leisure	Y/N	How Often weekly
Spend time with friends	☐		Sports / Exercise	☐	
Classes	☐		Dancing	☐	
Spend time with family	☐		Hobbies	☐	
Work part-time	☐		Watch movies / TV	☐	
Go "Downtown"	☐		Stay at home	☐	
Listen to music	☐		Spend time at clubs/bars	☐	
Go to Casinos	☐		Other:	☐	
What limits the client's leisure/recreational activities?					

Nutrition

Nutritional Status: Current Weight _____ Current Height _____ BMI _____

Appetite: ☐ Good ☐ Fair ☐ Poor, Please explain below

_____ Recently **gained/lost** significant weight

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Review of Medical History

Please elaborate on any condition you have.

Allergy
- ☐ Runny Nose
- ☐ Scratchy Throat
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Ear Fullness
- ☐ Sinus Congestion
- ☐ Sinus Drainage
- ☐ Itchy Nose

General
- ☐ Weight Gain
- ☐ Weakness
- ☐ Loss of Appetite
- ☐ Fever
- ☐ Breastfeeding
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

ENT
- ☐ Cold
- ☐ Cough
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Change in Voice
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ Sinus Pain/Headaches

Respiratory
- ☐ Chest Pain
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Chest Congestion
- ☐ Dyspnea
- ☐ Sleep Disturbance
- ☐ Difficult to breath lying down

Endocrinology
- ☐ Fatigue
- ☐ Excessive Thirst
- ☐ Weight Loss
- ☐ Sleep Disturbance
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Diabetes
- ☐ Thyroid Disorder

Cardiology
- ☐ Dizziness
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Rapid Heart Rate
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Leg Edema
- ☐ Leg Pain

Gastroenterology
- ☐ Nausea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Vomiting
- ☐ Blood in Stool
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Constipation

Urology
- ☐ Recurring UTI
- ☐ Blood in Urine
- ☐ Difficult Urinating
- ☐ Frequent Urination
- ☐ Nocturia
- ☐ Ulcerative/Interstitial Cystitis
- ☐ Other: _____
- ☐ Other: _____

Neurology
- ☐ Headache
- ☐ Seizures
- ☐ Insomnia
- ☐ Tic/Twitching
- ☐ Memory Changes
- ☐ Tingling/ Numbness'
- ☐ Dizziness
- ☐ Other: _____

Hematology
- ☐ History of Anemia
- ☐ Swollen Glands
- ☐ Easy Bruising
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Psychology
- ☐ Depression
- ☐ Anxiety
- ☐ High Stress
- ☐ Sleep Disturbance
- ☐ Suicidal Thoughts
- ☐ Substance Abuse
- ☐ Eating Disorder
- ☐ Agitation/Irritable
- ☐ Other: _____

Other
- ☐ Aneurysmal Vascular Disease or Arteriovenous Malformation

  including Thoracic or abdominal aorta, Intracranial & peripheral arterial vessels
- ☐ Hypersensitivity to Ketamine, or any other excipients
- ☐ Intracerebral Hemorrhage
- ☐ Intracerebral Hemorrhage

INITIAL INTAKE

Past Medical Health Treatment

Have you been diagnosed with mental health issues in the past? ☐ Yes ☐ No

If yes, what diagnosis have you had? _____

At what age were you first evaluated and/or treated for this? _____

Have you been treated for mental health issues with medications? ☐ Yes ☐ No

Have you had any of the following alternative treatments for mental health symptoms?

☐ ECT ☐ Transcranial Stimulation Vagal Nerve Stimulator ☐ Psychotherapy

☐ Other _____

Have you ever seen a therapist for mental health symptoms? ☐ Yes ☐ No

If yes, please provide the approximate date and name of provider _____

What mental health symptom were you seen by a therapist? _____

Do you feel it was productive for your mental health needs? ☐ Yes ☐ No

If no, explain: _____

Additional information you would like to share with your provider:

SIGNATURE (Person completing the form)

Name _____ Relationship to patient _____

Signature _____ Date _____