Name: _____

Date: _____

Midwest Ketamine Center, LLC.
1640 N. Arlington Heights Road, Suite 101
Arlington Heights, IL 60004
(O)224-232-8910 (F) 224-232-8920

Zung Self-Rating Anxiety Scale (SAS)

For each item below, please place a check mark (✓) in the column which best describes how often you felt or behaved this way during the past several days. Bring the completed form with you to the office for scoring and assessment during your office visit.

Place check mark (✓) in correct column.	A little of the time	Some of the time	Good part of the time	Most of the time
1 I feel more nervous and anxious than usual.				
2 I feel afraid for no reason at all.				
3 I get upset easily or feel panicky.				
4 I feel like I'm falling apart and going to pieces.				
5 I feel that everything is all right and nothing bad will happen.				
6 My arms and legs shake and tremble.				
7 I am bothered by headaches neck and back pain.				
8 I feel weak and get tired easily.				
9 I feel calm and can sit still easily.				
10 I can feel my heart beating fast.				
11 I am bothered by dizzy spells.				
12 I have fainting spells or feel like it.				
13 I can breathe in and out easily.				
14 I get feelings of numbness and tingling in my fingers & toes.				
15 I am bothered by stomach aches or indigestion.				
16 I have to empty my bladder often.				
17 My hands are usually dry and warm.				
18 My face gets hot and blushes.				
19 I fall asleep easily and get a good night's rest.				
20 I have nightmares.				

Source: William W.K. Zung. A rating instrument for anxiety disorders. Psychosomatics. 1971

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Questionnaire completed on visit date ☐ **or** specify date completed: _____
DD-Mon-YYYY

Only the patient (subject) should enter information onto this questionnaire.

PLEASE CHECKMARK THE ONE RESPONSE TO EACH ITEM THAT IS MOST APPROPRIATE TO HOW YOU HAVE BEEN FEELING OVER THE PAST 7 DAYS.

1. Falling asleep:
- ☐0 I never took longer than 30 minutes to fall asleep.
- ☐1 I took at least 30 minutes to fall asleep, less than half the time (3 days or less out of the past 7 days).
- ☐2 I took at least 30 minutes to fall asleep, more than half the time (4 days or more out of the past 7 days).
- ☐3 I took more than 60 minutes to fall asleep, more than half the time (4 days or more out of the past 7 days).

2. Sleep during the night:
- ☐0 I didn't wake up at night.
- ☐1 I had a restless, light sleep, briefly waking up a few times each night.
- ☐2 I woke up at least once a night, but I got back to sleep easily.
- ☐3 I woke up more than once a night and stayed awake for 20 minutes or more, more than half the time (4 days or more out of the past 7 days).

3. Waking up too early:
- ☐0 Most of the time, I woke up no more than 30 minutes before my scheduled time.
- ☐1 More than half the time (4 days or more out of the past 7 days), I woke up more than 30 minutes before my scheduled time.
- ☐2 I almost always woke up at least one hour or so before my scheduled time, but I got back to sleep eventually.
- ☐3 I woke up at least one hour before my scheduled time, and couldn't get back to sleep.

4. Sleeping too much:
- ☐0 I slept no longer than 7-8 hours/night, without napping during the day.
- ☐1 I slept no longer than 10 hours in a 24-hour period including naps.
- ☐2 I slept no longer than 12 hours in a 24-hour period including naps.
- ☐3 I slept longer than 12 hours in a 24-hour period including naps.

5. Feeling sad:
- ☐0 I didn't feel sad.
- ☐1 I felt sad less than half the time (3 days or less out of the past 7 days).
- ☐2 I felt sad more than half the time (4 days or more out of the past 7 days).
- ☐3 I felt sad nearly all of the time.

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)

PLEASE CHECKMARK THE ONE RESPONSE TO EACH ITEM THAT IS MOST APPROPRIATE TO HOW YOU HAVE BEEN FEELING OVER THE PAST 7 DAYS.

Please complete either 6 or 7 (not both)

6. Decreased appetite:

- ☐0 There was no change in my usual appetite.
- ☐1 I ate somewhat less often or smaller amounts of food than usual.
- ☐2 I ate much less than usual and only by forcing myself to eat.
- ☐3 I rarely ate within a 24-hour period, and only by really forcing myself to eat or when others persuaded me to eat.

7. Increased appetite:

- ☐0 There was no change in my usual appetite.
- ☐1 I felt a need to eat more frequently than usual.
- ☐2 I regularly ate more often and/or greater amounts of food than usual.
- ☐3 I felt driven to overeat both at mealtime and between meals.

Please complete either 8 or 9 (not both)

8. Decreased weight (within the last 14 days):

- ☐0 My weight has not changed.
- ☐1 I feel as if I've had a slight weight loss.
- ☐2 I've lost 2 pounds (about 1 kilo) or more.
- ☐3 I've lost 5 pounds (about 2 kilos) or more.

9. Increased weight (within the last 14 days):

- ☐0 My weight has not changed.
- ☐1 I feel as if I've had a slight weight gain.
- ☐2 I've gained 2 pounds (about 1 kilo) or more.
- ☐3 I've gained 5 pounds (about 2 kilos) or more.

10. Concentration/decision-making:

- ☐0 There was no change in my usual ability to concentrate or make decisions.
- ☐1 I occasionally felt indecisive or found that my attention wandered.
- ☐2 Most of the time, I found it hard to focus or to make decisions.
- ☐3 I couldn't concentrate well enough to read or I couldn't make even minor decisions.

11. Perception of myself:

- ☐0 I saw myself as equally worthwhile and deserving as other people.
- ☐1 I put the blame on myself more than usual.
- ☐2 For the most part, I believed that I caused problems for others.
- ☐3 I thought almost constantly about major and minor defects in myself.

12. Thoughts of my own death or suicide:

- ☐0 I didn't think of suicide or death.
- ☐1 I felt that life was empty or wondered if it was worth living.
- ☐2 I thought of suicide or death several times for several minutes over the past 7 days.
- ☐3 I thought of suicide or death several times a day in some detail, or I made specific plans for suicide or actually tried to take my life.

EPI0905.QIDSSR

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)

PLEASE CHECKMARK THE ONE RESPONSE TO EACH ITEM THAT IS MOST APPROPRIATE TO HOW YOU HAVE BEEN FEELING OVER THE PAST 7 DAYS.

13. General interest:

- ☐0 There was no change from usual in how interested I was in other people or activities.
- ☐1 I noticed that I was less interested in other people or activities.
- ☐2 I found I had interest in only one or two of the activities I used to do.
- ☐3 I had virtually no interest in the activities I used to do.

14. Energy level:

- ☐0 There was no change in my usual level of energy.
- ☐1 I got tired more easily than usual.
- ☐2 I had to make a big effort to start or finish my usual daily activities (for example: shopping, homework, cooking or going to work).
- ☐3 I really couldn't carry out most of my usual daily activities because I just didn't have the energy.

15. Feeling more sluggish than usual:

- ☐0 I thought, spoke, and moved at my usual pace.
- ☐1 I found that my thinking was more sluggish than usual or my voice sounded dull or flat.
- ☐2 It took me several seconds to respond to most questions and I was sure my thinking was more sluggish than usual.
- ☐3 I was often unable to respond to questions without forcing myself.

16. Feeling restless (agitated, not relaxed, fidgety):

- ☐0 I didn't feel restless.
- ☐1 I was often fidgety, wringing my hands, or needed to change my sitting position.
- ☐2 I had sudden urges to move about and was quite restless.
- ☐3 At times, I was unable to stay seated and needed to pace around.

Rush et al, Biol Psychiatry (2003) 54: 573-83.

EPI0905.QIDSSR

I confirm this information is accurate.	Patient's/Subject's initials:	Date:

QIDS-SS

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SCORE SHEET)

NOTE: THIS SECTION IS TO BE COMPLETED BY THE STUDY PERSONNEL ONLY.

_____ Enter the highest score on any 1 of the 4 sleep items (1-4)

_____ Item 5

_____ Enter the highest score on any 1 of the appetite/weight items (6-9)

_____ Item 10

_____ Item 11

_____ Item 12

_____ Item 13

_____ Item 14

_____ Enter the highest score on either of the 2 psychomotor items (15 and 16)

_____ **Total Score (Range: 0-27)**

Rush et al, Biol Psychiatry (2003) 54: 573-83.

EPI0905.QIDSSR

Midwest Ketamine Center, LLC.
1640 N. Arlington Heights Road, Suite 101
Arlington Heights, IL 60004
(O)224-232-8910 (F) 224-232-8920

Consent for Ketamine Infusion (Mood Disorder Treatment)

Patient, Please initial as you read and understand ↓

Patient Name: _____ DOB: _____/_____/____

_____ I have been informed Ketamine has not been approved by the Food and Drug Administration to treat mood disorders. This is an off-label use of Ketamine.

_____ Although Ketamine shows a 70% success rate, this medication may not help your mood disorder or may worsen your mood disorder.

_____ Side effects are dose dependent and the doses used to treat mood disorders are lower than the doses for anesthesia. Side effects may occur but often go away on their own. There are no reported long term side effects of Ketamine. Common side effects include, but are not limited to, vivid dreams, nausea, vomiting, increased saliva production, blurred vision, dizziness, out of body experience during infusion, increased heart rate, disrupted motor skills, and increased blood pressure.

_____ Uncommon and rare side effects include jerky arm movements, double vision, rash, increased intraocular pressure, allergic reaction and low blood pressure.

_____ Individuals with a history of drug use or dependence can develop a dependency on Ketamine.

_____ Ketamine is also used for sedation in surgery, though the doses used for mood disorder are much smaller.

_____ Ketamine may cause over sedation and require medical intervention including intubation.

_____ There is a risk of medication interaction. I have truthfully and accurately disclosed all medications I am taking, including all controlled substance medications such as benzodiazepines and/or pain medications.

_____ I understand that I will need transportation to and from the center and that I cannot drive after the infusion for at least 24 hours.

_____ I understand the treatments performed in the center involve payment and the fee structure has been explained to me. I will provide 48 hours notice of cancellation so that the treatment time can be made available to others. I understand that in the case of a missed appointment, I will be responsible for a missed appointment charge of $100.00.

_____ In the event of an adverse outcome, I agree to voluntary mediation to resolve the matter.

_____ It is mutually agreed in the event of an unsuccessful procedure of complications, proof of which shall be provided, my sole remedy shall be, upon my request, a refund of monies paid by me to the center. This shall be my sole irrevocable remedy. I release the facility, physicians, and staff from any liability whatsoever.

_____ No guarantee, warranty, or assurance concerning treatment results have been made to me either verbally or in writing.

_____ I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I freely consent to the terms of this agreement.

Patient's Signature _____ Date _____

Patient's Representative (for minors only) _____ Date _____

Relationship of Patient Representative to Patient _____

MOOD DISORDER HEALTH HISTORY QUESTIONNAIRE

Last Name: _____ **First Name:** _____ **MI:** _____

DOB: / / **DATE:** / /

Primary Phone #: _____ Alternate Phone #: _____

Email Address: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____ Relation to Patient: _____

Primary Care Physician Name: _____ Phone #: _____

Psychiatrist Name: _____ Psychiatrist Phone #: _____

Psychiatrist Diagnosis (list all): _____

Psychiatric Medications	Dose	Frequency

Psychiatric Medications Tried But Discontinued: _____

Other Medications:	Dose	Frequency

	Yes	No		
1.	❑	❑	Currently taking benzodiazepines?	Approx. Height: _____ Approx. Weight: _____
2.	❑	❑	Currently taking opiates?	

Allergies to Medication: _____

Other Medical Problems: _____

MOOD DISORDER HEALTH HISTORY QUESTIONNAIRE

Last Name: _____ **First Name:** _____

Past Surgical History: _____

Hospitalizations: _____

Psychiatric Hospitalizations: _____

Previous Anesthesia Experience: _____

Any Reactions to Anesthesia: _____

Substance Use	Frequency	For How Many Years?	Last used
Tobacco			
Alcohol			
Marijuana			
Cocaine			
Heroin			
Other			

Family History: _____

Your Occupation: _____

I certify that I have personally completed this form and that this form is accurate and complete to the best of my knowledge.

_____ _____

Patient's Signature Date

_____ _____

Patient's Representative (for minors only) Date

_____

Relationship of Patient Representative to Patient

We are required by law to maintain the privacy of, and provide individuals with, the Notice of our legal duties and Privacy Practices with respect to your Protected Health Information. If you have any objections to this form and/or have any questions regarding this form, please ask to speak with our HIPAA Compliance Officer in person or by phone. Also, we have provided you with the Patient Rights and Responsibilities information.

Your signature below is acknowledgement that you have received the Notice of our Privacy Practices, Patient Consent, Patient Responsibilities information.

Date: _____

Print Name: _____ Signature: _____

Midwest Ketamine Center info@midwestketaminecenter.com
1640 N Arlington Heights Rd Suite 101 Arlington Heights IL 60004 • (224) 232-8910•Fax (224)232-8920

MEDICAL RELEASE OF INFORMATION

Midwest Ketamine Center • 1640 N Arlington Heights Rd Suite 101
Arlington Heights IL 60004 • (224) 232-8910 • Fax (224) 232-8920
info@midwestketaminecenter.com

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____
Street Address

_____ Email address: _____
City State Zip

I HEREBY AUTHORIZE:

_____
Name of person/organization releasing records

_____
Street Address

_____
City St Zip

_____
Phone Number Fax Number

TO RELEASE INFORMATION TO:

Midwest Ketamine Center
Name of person/organization receiving records

1640 N. Arlington Heights Road, #101
Street Address

Arlington Heights IL 60004
City St Zip

(224) 232-8910 (224) 232-8920
Phone Number Fax Number

I understand that the entire medical record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatments, will be provided.

- This authorization is effective unless revoked or terminated by the patient or the patient's personal representative. If no expiration date is given, the expiration date of this authorization is one year from the date signed.
- You may revoke or terminate this authorization by submitting a written request. It will be effective on the date notified except to the extent action has already been taken.
- The information disclosed under this authorization may be disclosed again by the person or organization to which it is sent and may no longer be protected under federal privacy regulations.
- I understand that Midwest Ketamine Center will not condition treatment on whether or not I sign this authorization.

If you wish to obtain copies of your PHI, we will arrange to have the information copied. We may legally be prohibited from making certain information available to patients or patient representatives including: psychotherapy notes, information related to legal proceedings, information that federal or state laws prevent us from disclosing, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, and information that was obtained under a promise of confidentiality.

_____ _____ _____
Signature of patient, parent of minor, or personal representative Relationship Date

_____ _____
Signature of Staff Member Date