RAINFALL
MEDICINE

Confidential Client Information

Greetings! Thank you for reaching out to Rainfall Medicine. We look forward to exploring how we can support you in your journey. Please fill out this assessment form to the best of your ability. If you have any questions or concerns please let us know by reaching out via email.

1. Name: _____

2. Gender Identity and Pronouns: _____

3. Address: _____
_____

4. Home phone: _____ Cell phone: _____

5. Email: _____

6. Birthdate: _____

7. Occupation: _____

8.Emergency contact: _____
Relationship to you: _____
Phone: _____
What does your support system look like? ie partner, community, friends, family etc…
_____
_____
_____

9. Primary physician: _____ Phone: _____

10. Past Medical History / Surgeries:
_____
_____
_____
_____
_____

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11. Allergies: _____
_____
_____

12. Current Medications and Dose:
Have you found these medications helpful?
_____
_____
_____

13. Recreational Drugs, Method, Frequency, Last Date Used:
_____
_____
_____
_____
_____
_____

14. Have you had a drug or alcohol dependency? _____

15. Are you currently experiencing overwhelming sadness, grief, or depression?
_____
_____

16. Are you currently experiencing anxiety or panic attacks?
_____
_____

17. Are you, or could you be, pregnant? _____
Form of birth control if applicable: _____
Do you have children? _____
If so, how many and what are their ages? _____
_____
_____
_____
_____

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18. Are you currently seeing a therapist? _____
If so, how often? _____
What is the name of your therapist?_____
Are you open to signing a Release of Information form for us to consult with your provider? _____

19. Have you been prescribed psychiatric medications in the past? If so, please list the names of the medications and describe their effects:

_____
_____
_____
_____

20. Are you currently feeling actively suicidal?_____
Do you engage in self-harm behaviors? _____

21. Have you ever been hospitalized for a psychological difficulty? _____
If so,can you share more about this experience (why and when)?

_____
_____
_____
_____

22. In your own words, what is the nature of the concern that you wish to address in these sessions? What are your goals and intentions for seeking Ketamine Assisted Psychotherapy (KAP)?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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23. We understand that recounting trauma can be triggering for some individuals. To the best of your ability, can you share dates or age ranges of significant trauma/abuse that you have experienced. And if you prefer to speak to it in person, please feel free to write that below. This information helps us build and hold an informed container for your work as trauma can arise in Ketamine Assisted Psychotherapy (KAP) work.

24. In your process of healing, what have you found that helps or supports your most? What have you identified as being unhelpful?

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Below is a list of medical conditions. Please respond with YES (Y) or NO (N) for present or past conditions. If you are unsure, leave a blank.

Allergies		History of Psychosis / Schizophrenia	
Anemia		Stroke	
Asthma		Intestinal / Digestive Issues	
Auto-Immune Disease		Thyroid Disease	
Bipolar Disorder		Skin Problems	
Cancer		Joint Pain	
Diabetes		Sleep Apnea	
History of Heart Attack or Heart Disease		Chronic Pain	
Chest/Heart Conditions		Cognitive Problems	
High Blood Pressure		Chronic Infections	
Low Blood Pressure		Weight Loss / Gain	
History of Liver Disease or Current Liver Problems		History of Kidney Disease / Current Kidney Problems	

Please describe any condition for which you indicated YES (Y) above.
Please indicate whether they are past or present conditions.

_____
_____
_____
_____
_____
_____
_____
_____
_____

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Have you ever experienced any of the following, please indicate YES (Y) or NO (N):

Rapid Speech		Unexplained Memory Lapses	
Panic Attacks		Eating Disorders	
Phobias		PTSD	
Sleep Disturbances		Repetitive Thoughts (e.g. obsessions)	
Unexplained Losses of Time		Repetitive Behaviors (e.g. frequent checking, hand washing, etc…)	
Hallucinations			

For any box that you checked YES (Y), please describe the details briefly:

_____
_____
_____
_____
_____
_____

If you have any of the symptoms below, please use the indicated number scale to best describe the severity. If you don't have symptoms, leave blank.
0 = rarely 1 = mild/sometimes 2 = moderate/often 3 = severe/constant

Anxiety		Stress Management Difficulties	
Hopelessness		Nervousness	
Mood Swings		Irritability	
Depression		Fearfulness	
Loneliness / Social Isolation		Food Management Issues	
Anger Management / Bad Temper		Nightmares	

In general, how satisfied are you with your life?

_____

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The following questions are in regards to your relationship to food and your body.

How would you describe your relationship with food and your body?

_____
_____
_____
_____
_____

For the following questions, please respond with YES (Y) or NO (N):

1. Do you deliberately try to limit the amount of food you eat to influence your weight or shape?

2. Do you experience a fear of weight gain?

3. Has thinking about food, eating or calories made it very difficult to concentrate on things you are interested in?

4. Do you try to control your weight or shape by making yourself sick (vomit) or with laxatives?

5. Do you exercise in a compulsive way as a means of controlling your weight, shape or body fat?

6. Do you experience a loss of control over your eating (at the time of eating)?

7. Do you feel guilty after eating?

8. Does your weight or shape influence how you think about (judge) yourself as a person?

9. If you answered yes to any of the questions above, how long has this been an issue in your life?

   _____