HARMONY
THERAPY SERVICES

Phone: 515-981-2772 | Fax: 515-954-2771
www.harmonytherapyservices.com

KAP REFERRAL FORM – BY CLIENT

Client Information

Client Name: _____ Date of Birth: _____

Phone number: _____

Email: _____

How did you hear about Harmony Therapy Services? _____

Medical History:

Allergies: _____

Medical Considerations (including chronic illnesses, hospitalizations, and surgical history):

_____

_____

_____

Mental Health History:

Current mental health diagnoses (with ICD-10 Code, if known):

_____

_____

_____

Duration of Symptoms: _____

Are you currently in therapy? _____ YES _____ NO

Therapy Start Date: _____

Provider name and contact:

_____

_____

Have you been in therapy before? _____ YES _____ NO

Current Symptoms:

_____

_____

_____

Suicidal Ideations Present? _____ YES _____ NO

Past suicide attempt? _____ YES _____ NO

Are you currently taking medications? _____ YES* _____ NO

*Prescriber name: _____

Current medications and dosages:

_____

_____

_____

Have the medications been effective in reducing symptoms? _____ YES _____ NO _____ PARTIALLY

If you are not currently taking medication, have you in the past? _____ YES _____ NO

Please list previous medications, dates of usage, start/stop dates:

_____

_____

_____

Please share why you are interested in Ketamine-Assisted Psychotherapy and provide any other relevant notes about your history:

_____

_____

_____

_____

_____

By signing this document, I affirm I am the person represented on this form and have completed it with accuracy to the best of my knowledge.

Printed Name: _____

Signature: _____ Date: _____

Please return this form to kelsi@harmonytherapyservices.com