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Full Name:	**Date:**
Age:	**Pronoun(s):**
Birthdate (mm/dd/yyyy):	**Birth Gender:**
Email:	**Address:**
Phone:	**City, State Zip:**
Body Weight (pounds):	**Mailing Address: (if different)**

PURPOSE

What are your goals, hopes, or expectations for this work? What are you seeking?

HISTORY WITH PSYCHEDELICS

Have you ever taken psychedelics? ☐ Yes. If yes, what was your experience? ☐ No
Has it been in a ☐ **Recreational** or ☐ **Ceremonial** context?
Please describe in detail the type of substance taken, when, how much (if known), and the situation or purpose of taking the substance.

What influence have these experiences had on your life?

During these experiences, what types of difficulties have you worked through? What insights have you had?

Have you had any challenging or problematic experiences while using psychedelics?
☐ Yes ☐ No
If yes, please describe in detail what you took and what happened:

SUBSTANCE USE

Have you ever used alcohol, drugs, or consciousness-altering substances? ☐ Yes ☐ No

Please describe your use of any substances throughout your life and ***especially during the past 3 months***.

Have you had any significant adverse reactions to alcohol, drugs, or any consciousness-altering substances? ☐ Yes. ☐ No

If yes, please describe in detail the type of substance taken, when, how much (if known), the situation or purpose of taking the substance, and any adverse reaction(s).

Do you have any history of substance abuse? ☐ Yes. If yes, please describe. ☐ No

Have you ever been treated for substance abuse? ☐ Yes. If yes, please describe. ☐ No

Has anyone in your life ever described your substance use as problematic? ☐ Yes ☐ No

How much tobacco, alcohol, coffee, tea, and/or soda do you consume?

	Amount	
Cigarettes (# per day):		
Alcohol (drinks per day):		Per week:
Cannabis (times per week):		
Cups of coffee (per day):		
Cups of tea (per day):		
Soda (ounces per day):		

Are you allergic to, sensitive to, or tolerant/intolerant to any substances (including substances such as Novocain and/or pain killers)? ☐ Yes. If yes, please describe: ☐ No

Have you ever had an allergic reaction to consuming mushrooms or other fungi? ☐ Yes ☐ No

MENTAL HEALTH

Reminder: if you do not feel comfortable answering some of these questions it is okay to skip them. It is recommended that you mark "Lets discuss in person" so your practitioner can have a caring, careful conversation with you.

On a scale of 1-5 (where **1** = *Very Disappointed*, **5** = *Very Satisfied*):
In general, how satisfied are you with your life? ☐

To what extent do you have the following symptoms/issues:

Anxiety	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person
Depression	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person
Bad Temper	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person
Hopeless Outlook	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person
Lonely	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person
Easily Stressed	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person
Poor Memory	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person
Angry Outbursts	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person
Nervousness	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person
Dislike Criticism	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person
Poor Self-Esteem	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person
Body Image	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person
Lost	☐ Never	☐ Sometimes	☐ Often	☐ Constant	☐ Lets discuss in person

Do you have any current or past psychological or psychiatric conditions or diagnoses?
☐ Yes ☐ No

Do you suspect that you may have an undiagnosed condition or mental health issue?
☐ Yes ☐ No

In the past 5 years have you experienced impairment in your day-to-day functioning from a mental health issue?
☐ Yes ☐ No

Have you experienced memory loss, feeling detached from yourself and your emotions, or feeling like you or the world is unreal, or what feels like an abnormal level of checking-out/spaciness?
☐ Yes ☐ No

Do you currently see a psychiatrist, psychologist, or counselor? How often?

☐ Yes How often: ☐ ☐ No

Have you ever been hospitalized for a psychiatric condition? If yes, please give the dates and circumstances.

☐ Yes ☐ No

Have you ever intended or attempted suicide, or had suicidal thoughts? If yes, please provide the details.

☐ Yes ☐ No

Have you ever engaged in self-harm or destructive behavior to self or others?

☐ Yes ☐ No

Have you ever had a seizure? Please explain if so.

☐ Yes ☐ No

Have you ever had a manic or hypo-manic episode (i.e. times when you had extreme reductions in sleep, or may have engaged in very high-risk behavior outside of your normal range for a significant timeframe, or had a much higher than normal elevated mood or energy, rapid thoughts and ideas, or feelings of invincibility)?

☐ Yes. If yes, please describe: ☐ No

Have you ever experienced a break from reality / psychosis?

☐ Yes. If yes, please describe: ☐ No

Trauma may result from a single incident, such as a car accident or witnessing violence or death. Trauma may result from repeated and prolonged exposure to (for example) domestic violence or abuse, or to varied and multiple events of an invasive/often interpersonal nature. Have you experienced trauma that you know of?

☐ Yes ☐ No ☐ Lets discuss in person

If yes, please note anything you are comfortable sharing about it:

Have you ever been abused?

☐ Yes ☐ No ☐ Lets discuss in person

If yes, was the abuse: ☐ physical ☐ mental ☐ emotional ☐ sexual? (check all that apply)

Do you have any issues around trust?

☐ Yes. If yes, please describe: ☐ No

Do you experience extreme anxiety, fear, or paranoia?

☐ Yes. If yes, how often? Please describe. ☐ No

Did anyone in your immediate family experience any major mental or physical health crises or conditions, trauma, or extreme stress while you were growing up? This could include things like: loss of family members; job loss; divorce; abuse; mania; bipolar disorder; psychosis; chronic depression or anxiety.

☐ Yes ☐ No ☐ Lets discuss in person

How much do you like yourself?

What are some of your virtues or strengths?

Is there anything you do not like about yourself?

What qualities do you admire in others?

Do you feel guilty or ashamed of anything?

If you were to list 3 difficult feelings that most often arise in you, what would they be?

MEDICAL HISTORY

How would you describe your health?

Do you have a history or present condition of high or low blood pressure?

☐ Yes. If yes, please explain. ☐ No

Are you able to carry a bag of groceries up stairs without needing to take a break? ☐ Yes ☐ No

Could you be pregnant? ☐ Yes ☐ No

Do you have any abnormal findings from any recent physical exams or blood work?

☐ Yes. If yes, please explain. ☐ No

For the following, please describe event and list date of occurrence(s):

Surgery/surgeries:

Major Accident(s):

Hospitalization(s):

Do you have any of the following conditions?

Anemia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Autoimmune Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Cardiovascular Disease	☐ Yes	☐ No
Irregular Heart Rate	☐ Yes	☐ No
Seizure Disorder	☐ Yes	☐ No

What prescription medications are you currently taking?
►**NOTE:** It is ***essential*** that you list **ALL prescription medications**.)

Medication	Dosage	For What?	Since When?

►***ALERT:*** It is ***very important*** to share **ANY** changes or adjustments to your current medications ***PRIOR TO your psilocybin administration session.***

Have you had any ***adverse reactions*** to the above listed medications (current or past)? Have you experienced or are you currently experiencing any side effects from these medications?

☐ Yes. If yes, please explain. ☐ No

Are you more, or less, sensitive to medications than most people? (i.e. Have you had to take more or less of a medication's recommended dose to experience the desired effects?)

☐ Yes. If yes, please explain. ☐ No

What **supplements** are you taking or do you anticipate you will be taking at the time of your psilocybin session? Be sure to include any vitamins, minerals, herbs, homeopathic, other health aids including St. John's Wort.

Supplement	Dosage	For What?	Since When?

Do you eat grapefruit or drink grapefruit juice regularly? ☐ Yes ☐ No

Are there any medications that must or may not need to be taken during the psilocybin administration session? (For example: an EpiPen or insulin.)

☐ Yes. If yes, please explain. ☐ No

Do you currently rely on any medical devices? (For example: a catheter, or an insulin pump)

☐ Yes. If yes, please explain. ☐ No

Do you have any allergies that could get triggered during a psilocybin administration session?
☐ Yes. If yes, please explain. ☐ No

FAMILY / RELATIONSHIPS

Relationship status:
Are you currently in a romantic relationship? ☐ Yes ☐ No
If yes, for how long have you been in relationship:

On a scale of 1-10 (1 = *Low*, 10 = *High*):
How would you rate your satisfaction with your current romantic relationship(s):
Please describe why you chose your rating:

Who are the most important people in your life?

Do you feel comfortable asking for help if needed? ☐ Yes ☐ No
Who is looking out for you?

Children, if any? (Please list ages.)

Are your parents still living? **Mother:** ☐ Yes ☐ No **Father:** ☐ Yes ☐ No

If **NO**: What age were you when your parent(s) passed (if applicable):

If **YES**: Do you currently have a relationship with your **mother**? ☐ Yes ☐ No

If **YES**: Do you currently have a relationship with your **father**? ☐ Yes ☐ No

Did your parents go through a separation? ☐ Yes ☐ No

If yes, what age were you when they separated? What was the custody arrangement?

Do you have siblings? ☐ Yes ☐ No
If yes, please list their ages:

Please describe the composition of the family you grew up in?
(ie, mom, dad, siblings, grandparents, step-parents, step-siblings, etc.)

SOCIAL HISTORY:

In your family of origin and/or in the family you were raised in was there were any of the following present?

Neglect	☐ Yes	☐ No
Violence between adults	☐ Yes	☐ No
Violence between family members	☐ Yes	☐ No
Deaths	☐ Yes	☐ No
Alcohol abuse	☐ Yes	☐ No
Other drug or substance abuse	☐ Yes	☐ No
Strong religious/spiritual practice	☐ Yes*	☐ No

*IF yes, did this religious/spiritual practice feel oppressing? ☐ Yes ☐ No

Absent parent	☐ Yes	☐ No
Depressed parent(s)	☐ Yes	☐ No
Parental instability	☐ Yes	☐ No
Trauma	☐ Yes	☐ No
Abuse (physical, sexual, emotional)	☐ Yes	☐ No

Any additional comments you'd like to share?

How supported by your family do you feel?

Who do you live with?

Are you living with conflict? ☐ Yes ☐ No

What is your current living situation? Are you housed / unhoused? How stable does your current living situation feel to you?

Please describe any pets you have:

DIET

Any dietary restrictions? ☐ Yes. If yes, please describe: ☐ No

Do you struggle with disordered eating or exercise? ☐ Yes. If yes, please describe: ☐ No

Do you find food is enjoyable, or a burden?

SLEEP

Number of hours per night?

Do you wake feeling refreshed? ☐ Yes ☐ No

Do you have issues falling asleep? ☐ Yes ☐ No

PERSONAL

Are you at a place in your life where you can handle some instability for a while?

☐ Yes ☐ No

Do you have a spiritual or contemplative practice?

☐ Yes. If yes, please explain. ☐ No

What are your coping mechanisms? How do you deal with stress and life challenges?

What do you do for self-work / growth?

Do you have hobbies? What do you enjoy in your free time?

Who do you rely on for emotional support?

Do you have a social network? ☐ Yes ☐ No

Are you satisfied with your social relationships? ☐ Yes ☐ No

What (if any) groups or communities are you a part of?

Are you involved in any stressful legal disputes or lawsuits?

☐ Yes. If yes, please describe. ☐ No

SEXUALITY

Describe your sexual development, orientation, and expression.

INTEGRATION

What friend, loved one, counselor, or other trusted person(s) do you speak with about this work? What do they think about you pursuing this work?

Do you have a network of support to assist you in integrating this work?

☐ Yes. If yes, please describe. ☐ No

What practices have you found helpful in integrating powerful life experiences? (i.e. art, bodywork, journaling, time in nature, speaking with a friend, etc.)

Counseling is recommended to support your integration. If you are not already a regular client, who will support your integration and how will you utilize them?

What else do you want to share with us about yourself, or what questions do you want to discuss?

LANGUAGES

What language(s) do you speak fluently?

What language(s) did you grow up speaking:

Will you require assistance from an interpreter during an administration session?

☐ Yes. If yes, please describe. ☑ No

ADDITIONAL SUPPORT

Do you require any assistive mobility devices?

☐ Yes. If yes, please describe. ☐ No

Will you require assistance from a client support person for augmentative and alternative communication (AAC) device support or assistive listening device support during the administration session?

☐ Yes. If yes, please describe. ☐ No

Will you require assistance from a client support person for catheter, ostomy, or toileting assistance, ambulation or transfer mobility support, or medical device assistance during the administration session?

☐ Yes. If yes, please describe. ☐ No

Do you anticipate that you will need support from an additional person during the psilocybin administration session, such as a health aide?

☐ Yes. If yes, please describe. ☐ No

Will you require assistance to consume psilocybin products?

☐ Yes. If yes, please describe. ☐ No

EMPLOYMENT INFORMATION

What do you do/have you done for employment?

Level of satisfaction w/your current position on a 1-5 scale (1=poor/5=high):

Briefly describe your work activities: