

IBOGREEN

www.IboGreen.com

Playas Tijuana, MX

ph: (619) 750-2218 e: Grow@IboGreen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named below. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message.

**General Information**

What do you want to achieve from Ibogaine treatment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have pain and or have you had surgeries?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Information**

Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs.

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Y\_\_\_\_\_\_ N \_\_\_\_\_\_

# Cigarettes\_\_\_\_\_\_\_\_\_ /day? Or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / week?

Do you drink alcohol?

#\_\_\_\_\_\_\_\_\_ /day? (OR) #\_\_\_\_\_\_\_\_\_ /week? (OR) #\_\_\_\_\_\_\_\_/month

**Prescription Medication**

Do you take prescription medications? Y \_\_\_\_\_\_ N \_\_\_\_\_\_

If yes, please list all current names of prescription medications, frequency and dosages taken within the last 6 months. Circle the medications that are not prescription or not taken as the prescription is written.

**Drug Length of Time on Drug Intended Purpose**

**1.** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2.** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3.** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6.** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Over the Counter Medications**

**#1**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Length of Time on Drug Intended Purpose**

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**#2**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Length of Time on Drug Intended Purpose**

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**#3**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Length of Time on Drug Intended Purpose**

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**#4**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Length of Time on Drug Intended Purpose**

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Abused Drugs**

Do you abuse or take prescribed or un-prescribed medications?

Y: \_\_\_\_\_ N: \_\_\_\_\_

If yes, please list:

**#1**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**#2**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**#3**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**#4**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ibogaine Intention**

Please circle. Are you seeking Ibogaine for:

**A. Addiction**

* Eliminate opiate withdrawals:
	1. Short acting? \_\_\_\_\_\_\_\_\_\_ (Please put X)
	2. Long acting? \_\_\_\_\_\_\_\_\_\_
1. **Eliminate Heroin withdrawals**
2. Inhaled/snorted? \_\_\_\_\_\_\_\_\_\_ (Please put X)
3. Oral? \_\_\_\_\_\_\_\_\_\_ (Please put X)
4. Intravenous? \_\_\_\_\_\_\_\_\_\_ (Please put X)
5. Rectally? \_\_\_\_\_\_\_\_\_\_ (Please put X)
6. **Psycho-spiritual**
7. **Alcoholism**
8. **Other**

Name of drug (type of opiate / heroin): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage per day or week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Female patient**

LMP: Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Could you be pregnant? Y \_\_\_\_\_ N \_\_\_\_\_

# of past pregnancies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Live births? Y \_\_\_\_\_ N \_\_\_\_\_# \_\_\_\_\_\_\_\_\_\_\_

Current form of birth control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lengthy Medical History**

Do you have any of the following medical conditions? (Please Circle).

Y N Cerebrovascular disease (stroke, embolisms etc.)

Y N Convulsions and/or epileptic seizures

Y N Mental disorders

 Y N (Schizophrenia, bipolar disorder, anxiety, suicide

 attempts, other)

Y N Diabetes (insulin dependent? \_\_\_\_\_\_\_\_)

Y N Hypertension (if possible give last blood pressure reading \_\_\_\_\_\_\_\_\_\_\_\_)

Y N Cardiac or coronary disease

Y N Pulmonary disease (asthma, COPD, cancer, pneumonia, sarcoidosis, other)

Y N Gastrointestinal disease (gastritis, colitis, Crohn’s disease, cancer, other)

Y N Genital disease (herpes, syphilis, gonorrhea, other)

Y N Autoimmune disease (lupus, arthritis, scleroderma, psoriasis, other)

Y N Cancer

Y N Hypothyroidism

Y N Hyperthyroidism

Y N Infectious diseases (hepatitis A, B, C, D, E, HIV, other)

Y N Back problems

Y N Asthma

Y N Fainting, dizziness, shortness of breath

Y N Nerve damage

Y N Varicose veins

Y N Jaundice

Y N Any other disease or condition

**Medical Tests**

In the past 6 months, have you had any lab work? Y \_\_\_\_\_ N \_\_\_\_\_

 (If yes, please provide a copy of the results)

In the past 6 moths have you had an EKG? Y \_\_\_\_\_ N \_\_\_\_\_

 (If the answer is yes, please provide a copy of the results)

**Ibogaine Related Information**

 **(Intake provider will review this information with you)**

Contraindicatory medications to Ibogaine and associated times necessary to abstain:

* **Methadone** (at least 4 weeks last dose)
* **Amphetamine** (5 days last dose)
* **Methamphetamine** (5 days last dose)
* **Suboxone** (at least 4 weeks last dose)
* **Cocaine** (at least 5 days last dose)

IboGreen’s affiliated MDs, nurses and providers, do not taper and/or suspend prescription medications. It is necessary to consult with your treating physician to discuss tapering and/or suspending medication due to side effects.

Contra-indicatory medications to Ibogaine that need to be terminated 30 days prior to treatment:

* **Antidepressants** (Fluoxetine, sertraline, etc.)
* **Antipsychotics** (Chlorpromazine, levomepromazine, haloperidol, loxapine etc.)
* **Lithium**
* **Beta-blockers** (propranolol, metoprolol, etc.)

Contra indicatory medications to Ibogaine that need to be terminated 5 days prior to treatment:

* **Proton pump inhibitors** (nexium, omeprazole)
* **Antiemetics** (Ondansetron)
* **Quinolones** (ciprofloxacin, moxifloxacin)

**Ibogaine Related Information (continued)**

 **(Intake provider will review this information with you)**

A patient cannot be treated with ibogaine, if they present any of the following conditions:

* **Pregnancy**
* **Lactation**
* **Heart disease** (arrhythmias, previous infarction, heart failure, coronary surgery, cardiac surgery).
* **60 years of age or older**

 EXCEPTION: Cardiac stress test within 30 days.

* **17 years of age or younger**
* **Known allergy to Ibogaine**
* **Obesity with BMI of 35 or greater**
* **Hypertension without any control or difficult to control**
* **Decompensated diabetes**
* **Recent major surgeries (less than 2 years)**

EXCEPTION: Cardiac stress test within 30 days. MD approval

* **Convulsions**
* **Chronic and acute renal failure**
* **Ulcers**
* **QT prolongation** (Ibogaine cardiac specialist in Encinitas approval will be required).
* **Liver damage and/or failure**
* **Cancer**
* **Psychological disorders** in which prescriptions need to be suspended and/or terminated by prescribing MD and have not yet been resolved.

If you answered Y (yes) to any of the above conditions, please answer the following questions:

**Date of Diagnosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Associated Treatments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please sign, print and date to acknowledge veracity and integrity of your responses. IboGreen is not here to judge. We are here to give you the optimal support.

I have read and filled out the psychological intake and the medical intake. I understand the risks involved with ibogaine including the rare possibility of death. Some research demonstrates 1/300 fatalities, however it is not substantiated whether this statistic is based on the utilization of all precautionary measures being put into place including but not limited to: if proper equipment was available such as heart monitor and defibrillator and/or if lab work demonstrating liver enzyme functioning and EKG were administered. Was administration observed by an MD and paramedics? Was proper dosage given per weight. Was client honest about medical history? Was drug test clearance given to patient prior to administration. Did patient have IV inserted in case emergency medication needed to be administered?

Signed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last 4 digits SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_