

IBOGREEN

www.IboGreen.com

Playas Tijuana, MX

e: Grow@IboGreen ph: (619) 807-2127 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **General Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M\_\_\_\_\_\_\_ F\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Field of study: \_\_\_\_\_\_\_\_\_\_\_

What do you want to achieve from Ibogaine treatment?

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

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What activities are you involved in?

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

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**B1. Emergency Contact Information:**

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

Relationship to self: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B2. Secondary Emergency Contact Information:**

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

Relationship to self: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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1. **Personal Information**

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

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

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

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

Do you drink alcohol?

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

With whom do you live? List people including animals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. **Prescription Medication**

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

If yes, list:

* Names of prescription medications, frequency and dosages:

**#1**

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

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

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



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1. **Prescription Medication (continued)**

**#2**

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

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

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

**#3**

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

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

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

1. **Over the Counter Medications**

Do you take over the counter medications? Y: \_\_\_\_\_ N: \_\_\_\_\_

If yes, list:

* Names of prescription medications, frequency and dosages:

**#1**

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

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

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



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1. **Over the Counter Medications (continued)**

**#2**

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

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

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

**#3**

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

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

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

1. **Un-prescribed or abused prescribed drugs?**

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

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

If yes, list:

* Names of prescription medications, frequency and dosages:

**#1**

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

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

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



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1. **Un-prescribed or abused prescribed drugs? (continued)**

**#2**

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

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

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

**#3**

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

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

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

1. **Drinking**

Is drinking an issue for you? Y \_\_\_\_\_ N \_\_\_\_\_

Does drinking typically lead to other drugs? Y \_\_\_\_\_ N \_\_\_\_\_

What is the frequency of your drinking?

\_\_\_\_\_\_\_\_ glasses/shots per day

\_\_\_\_\_\_\_\_ glasses/shots per week

\_\_\_\_\_\_\_\_ glasses/shots per month



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



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**I. Medical History**

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

If yes, what are you allergic to (prescription, animals, medications, foods)

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

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

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

Epi-pen needed: Y \_\_\_\_\_\_ N \_\_\_\_\_\_

Will you bring with you? Y \_\_\_\_\_ N \_\_\_\_\_

* Age introduced to drug of issue: \_\_\_\_\_\_\_\_\_\_\_\_\_
* Length of Addictive use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Lengths of clean time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Ages of lengths of clean time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What triggered return to drug of choice? \_\_\_\_\_\_\_\_\_\_\_\_\_

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



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1. **Medical History (continued)**

Previous surgeries: Y \_\_\_\_\_\_ N \_\_\_\_\_\_

If Y, What were they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**J. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**K. 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



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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

**L. 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)



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**M. Ibogaine Related Information**

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

Contra indicatory 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.

Contraindicatory 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)



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**M. 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.

* **18 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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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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.

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

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

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

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