

Ibogaine Treatment Application Form

Please send filled up application to: info@ibogainetreatment.eu

1. First Name (required)
2. Surname (required)
3. Mobile (required)
4. Email (required)
5. Address (required)
6. Country (required)
7. Emergency Contact - First Name (required)
8. Emergency Contact - Surname (required)
9. Emergency Contact - Mobile (required)
10. Emergency Contact - Email (required)
11. Gender M/F (required)
12. Age (required)
13. Height (required)
14. Weight (required)
15. How did you hear about us?
16. I am seeking treatment for a) Substance Addiction, b) Mental Disorder, c) Psycho-Spiritual: (required)
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17. In case of substance addiction treatment - What substance(s) are you seeking detoxification from?:
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18. In case of substance addiction treatment - Have you ever been abstinent from the substance(s) you are seeking to detoxify from?:.....
19. In case of substance addiction treatment - Please provide a detailed chronological history of your substance use. (For example: 2003 - 2007 - 80mg of methadone one a day a day):
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20. In case of substance addiction treatment - Please list other detox or treatment programs you have participated in, and tell us why they did or didn't work for you:
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21. Date Requested:

- 22. Please provide a list of all medications you are prescribed, and are currently taking:
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- 23. Please provide a list of all medications you are prescribed, but are NOT currently taking:
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- 24. Please list all supplements, nutraceuticals or performance enhancers you've taken in the last month:
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- 25. Please list all foods and/or medications you are allergic to:
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- 26. Please list any major surgeries you've had in the past, including the date and reason for the procedure:
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- 27. If you are you suffering any emotional or mental conditions, please explain:
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- 28. If you have you ever been admitted to a psychiatric hospital, please explain:
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.....
- 29. If you have ever tried to commit suicide, please explain:
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.....
- 30. Do you suffer from any of the following conditions?
Bi-Polar | Depression | Severe Depression | Obsessive/Compulsive/Eating Disorders | PTSD | Schizophrenia:
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.....
- 31. If you've ever been a smoker, how much and how long:
.....
.....
- 32. Do you suffer from any of these physical conditions?
Slow Heart Rate | Heart Problems | Myocardial Infarction | Heart Disease | Low Blood Pressure | High Blood Pressure | Fainting | Vascular Disease | Varicose Veins | Abnormal Bleeding | Embolism | Blood Clotting | Aneurysm | Coughed Up Blood | Asthma | Shortness of Breath | Tuberculosis | Head Injury | Trauma to the body | Trauma to the pelvis or legs | Stroke | Seizures | Dizzy Spells | Abdominal Pain | Ulcers | Ulcerative Colitis | Crohn's | Peptic Ulcer | Diarrhea | Nausea | Urinary Problem | Renal Disease | Hepatitis A | Hepatitis B | Hepatitis C | Liver Problems | Jaundice | Joint Swelling | Joint Pain | Muscle Spasms | Diabetes | Hypoglycemia | Thyroid Problems History of Cancer | HIV Positive/AIDS | Insomnia
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- 33. Do you or your family have any history of cardiac abnormalities, heart attack or stroke? (required):

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34. Do you or your family have any history of long QT syndrome, sudden death or unexplained blackouts?
(required):

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35. Are you taking any steroids or hormones such as Human Growth Hormone? (required):

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36. Have you ever had a CYP2D6 metabolism test? if so, what was the result?:

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37. Please describe what you do in your career, work or study:

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38. What do you hope to achieve from your ibogaine treatment? (your intention or reason for treatment...)
(required):

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39. Is there anything else you would like to say?:

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*****By sending this application I hereby certify that the above information given are true and correct as
to the best of my knowledge*****

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