Ibogaine Treatment Application Form

Submitted application forwards to: info@ibogainetreatment.eu

1. First Name (required) ……..
2. Surname (required) ……..
3. Mobile (required) ……..
4. Email (required) ……..
5. Skype ID ……..
6. Address
    - Street address
    - Address line 2
    - City
    - County/Province/State
    - Zip/Post Code
    - Country
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. Marital Status ……
16. How did you hear about us? ……..
17. I am seeking treatment for a) Substance Addiction, b) Mental Disorder, c) Psycho-Spiritual: (required) [select a box] ……..
18. In case of substance addiction treatment - What substance(s) are you seeking detoxification from?: ……..……..
19. In case of substance addiction treatment - Have you ever been abstinent from the substance(s) you are seeking to detoxify from?:……..……..
20. If you have abstinent, what did you find helpful in maintaining abstinence? :……..……..
21. Please describe your usual withdrawal symptoms (if any) :……..……..

22. 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):
……
……
……
……
……

23. In case of substance addiction treatment - Please list other detox or treatment programmes you have participated in, and tell us why they did or didn't work for you:

……
……
……

24. Have you ever taken iboga or ibogaine before? If yes, please provide more information:……..……..

25. Please provide a list of all medications you are prescribed, and are currently taking:

……
……

26. Please provide a list of all medications you are prescribed, but are NOT currently taking:

……
……

27. Please list all supplements, nutraceuticals or performance enhancers you've taken in the last month:

……
……

28. Please list all foods and/or medications you are allergic to:

……
……

29. Please let us know if you have a restricted diet:

……
……

30. Please list any major surgeries you've had in the past, including the date and reason for the procedure:

……
……

31. If you are you suffering any emotional or mental conditions, please explain:

……
……

32. If you have you ever been admitted to a psychiatric hospital or been diagnosed with any psychiatric conditions, please explain:

……
……

33. If you have ever tried to commit suicide, please explain:

……
……

34. Do you currently suffer from any of the following conditions?
    Bi-Polar Disorder | Depression | Severe Depression | Obsessive/Compulsive/Eating Disorders | PTSD | Schizophrenia [select a box]

35. If you've ever been a smoker, how many cigarettes per day and for how long:

    ……..……..…….

36. Do you suffer from any of these medical conditions? [select a box/es]

Abdominal Pain

Abscess

Arrhythmia

Aneurysm

Asthma

Back problems

Bronchitis

Cancer

Cerebellar Dysfunction

Chronic Fatigue

Cluster headaches

Crohn's Disease

Diabetes

Diarrhea

Dizzy Spells

Epilepsy

Eye pain

Heart Disease

Hepatitis A

Hepatitis B

Hepatitis C

High Blood Pressure

HIV Positive/AIDS

Hypoglycemia

Insomnia

Jaundice

Joint Pain

Kidney Stones

Liver Problems

Low Blood Pressure

Muscle Spasms

Myocardial Infarction

Nerve damage

Obesity

Palsy

Peptic Ulcer

Pericarditis

Renal Disease

Sexually Transmitted Disease

Shortness of breath

Staph infection

Stroke

Tachycardia

Thyroid Problems

Trauma to the body

Tremors

Tuberculosis

Ulcerative Colitis

Ulcers

Urinary Problem

Varicose Veins

Vascular Disease

Venous Thrombosis

Other

If you answered yes to any of the preceding conditions, please provide details here:

……..……..…….……
……..……..…….

37. Do you or your family have any history of cardiac abnormalities, heart attack or stroke? (required):

……..……..…….……
……..……..…….

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

……..……..…….……
……..……..…….

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

……..……..……
……..……..……

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

……..……..……
……..……..……

41. Please describe your life goals and the things that are motivating you to recover:

……..……..……
……..……..……

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

……..……..……
……..……..……

43. Please describe your social support network (family, friends, co-workers)
……..……..……
……..……..……

44. Do you have any spiritual practices or beliefs?
……..……..……
……..……..……

45. Please describe your living environment. Do you consider it to be healthy or unhealthy?
……..……..……
……..……..……

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

……..……..……
……..……..……

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

……..……..……
……..……..……

48. Do you have the available financial resources and commitment for enrollment into our ibogaine treatment programme (€5000 single occupancy per week, €3,500 shared occupancy per week)? ……

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

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