

Create Heavens Clinic

Patient inquiry | 5-MeO-DMT

Type into the fields, save a copy, and return it to the clinic.
This initial inquiry is followed by a separate clinical screening.

Full name

Date of birth

Best phone number for us to call you back

Best time to call and time zone

Email address

City and country

How did you hear about us?

What brings you to the clinic and what would you like help with?

Current medications and important medical or mental health conditions

Any previous psychedelic experience or concerns you want us to know about?

☐ I agree the clinic may contact me about this inquiry.

Submitting this form does not confirm eligibility or provide consent for treatment.
Please return it through the clinic's designated secure channel.

If fields do not open in your preview, use a PDF app that supports fillable forms.