Date Received:_____

Transcranial Magnetic Stimulation (TMS) Patient Questionnaire

Full Name: _____

DOB: _____ **Cell Phone/Home Phone:** _____

Home Address: _____

Email Address: _____

INSURANCE Company: _____**Policy Number:** _____

INSURANCE Subscriber (If you are not the primary on your insurance):

Name of Subscriber: _____

Subscriber's Date of Birth: _____

Subscriber's Address (if not same as yours): _____

Referring Mental Health Provider (MD) (name/address/phone number):

_____

Primary Care Physician (name/address/phone number):

_____

In your words, what is the reason you have been referred for TMS treatment?

Do you have anything metal in your head, neck or upper chest that cannot be easily removed?

◯ **Yes** ◯ **No**

If so, what is it? _____

Do you or anyone in your family have a Seizure Disorder? (If "Yes," please explain):

_____

Current Psychiatric Presentation

- What current psychiatric concerns are you hoping to find improvement in with TMS treatments?

  How long have they been present? _____
- Any active thoughts of self-harm or suicide? If yes, please explain further.

- Any thoughts of wanting to harm others? If yes, please explain further.
  _____
- What other interventions are you currently undergoing?
  _____

- Current treatment
  - Current medications including dose, frequency, length of time at current dose

  - Other ongoing treatments/therapies
    _____
  - Pharmacy where your medications are filled (Name/location/phone)

    _____

- What diagnoses have been discussed with you regarding your mental health struggles?
  - Include all diagnoses/age received/any symptoms you remember with each diagnosis:

Current Medical History

- Current medical diagnoses that you are currently under the care of a physician for:

- Current medications including doses/side effects for other medical complaints (non-psychiatric medications):

- Any current symptoms of illness? If yes, please explain.

- Have you been vaccinated for COVID-19 or have you tested positive for COVID-19? (Provide details)

Past psychiatric treatment history *(Use separate sheet if needed for additional history)*

- **Past Inpatient treatment**
  - Date/Location/Reason
  - _____
- **Past Partial Hospital Program/Intensive Outpatient treatment**
  - Date/Location/Reason
  - _____
- **Past Residential or Substance Abuse treatment**
  - Date/Location/Reason
  - _____

Name: _____

- **Past Outpatient treatment**
    - First treatment contact
        - Age _____
        - What was the reason _____
    - Past outpatient providers (names/location/phone if known)
        - How long were you with them and what led to you moving on to a new provider?

    - Current treatment team and when care was initiated:
        - Psychiatrist/medication provider: _____
        - Therapist provider: _____
        - Other members of medical support team (i.e. case manager/social worker)? _____
- **Past psychiatric medication trials**
    - Please provide full list of all psychiatric medication trials in the past. If uncertain, write down what you can remember and consider calling your pharmacy for a list of trials

      ** Include name of medication, dose, length of treatment, possible side effects, reason discontinued.
        - _____
        - _____
        - _____
        - _____
        - _____
        - _____
- Other treatment interventions in the past (i.e. ECT, Deep Brain Stimulator, Vagal Nerve Stimulator, Ketamine infusion)

Past Medical History (please include date of occurrence)

- History of head trauma (i.e. Traumatic Brain Injury, concussion): _____
- History of aneurysms, brain surgery, metal implants including clips/plates, coils:

- History of strokes/Transient Ischemic Attacks: _____
- History of asthma/respiratory pathology: _____
- History of cardiac events: _____
- History of surgeries (list): _____
- Other medical history: _____

What are your concerns, if any, about initiating TMS Treatment?

Name: _____

Please complete this form to the best of your ability and in its entirety. If certain information in not known (i.e., doses of past medications) sometimes this information can be found by calling your pharmacy or your doctor. By completing this ahead of time, it allows us more time to discuss your options and provide the best next steps in treatment. If you have questions about any of the information requested, please mark that area, and proceed to the next section. We will discuss it during your consultation.

We look forward to working with you and assisting you in your mental health needs.

- The TMS Treatment Team