Patient's Name:

Date of Birth:

Insurance Carrier and Insurance Number:

Current Family Physician and Phone Number:

Current Psychiatrist and Phone Number:

Current Therapist and Phone Number:

Allergies (Food and Medicine)

Please underline items under A or B that may apply to you:

A. Indications for TMS you are seeking treatment for that are covered by BCBS and Medicare insurance:

Unipolar Depression- Failed to recover from 4 or more medications and a trial of psychotherapy in this episode of depression.

Bipolar Depression- willing to be enrolled in a clinical research trial

B. Indications for ECT you are seeking treatment for that are covered by most insurances:

Unipolar or Bipolar Depression
Refractory Hallucinations from Schizophrenia
Bipolar Mania

Current Clinical Symptom History Please underline all that apply:

Depression- sleep disturbance, loss of interest, excessive guilt, low energy, loss of concentration, appetite changes, thoughts of wishing you were not alive, lasting greater than 2 weeks.

Mania- highly distractibility, decreased need for sleep, high energy, grandiosity, rapid thinking that is out of control, excessive talkativeness, hypersexuality, excessive increased activity that lasts 4 or more days.

Psychosis- seeing or hearing things that other people can't see or hear, disorganized thinking that makes it difficult to attend to basic tasks that have occurred for 1 month or longer

Substance use- How frequent? For how long? Current use?
Tobacco-_____
Alchohol-_____
Cocaine-_____
Marijuana-_____
Opiods (not prescribed)-_____
Synthetic substances-_____

Medications you are taking now:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Medications you've taken before, maximum dosage, and length of taking, and any side effects.
Prozac (fluoxetine) _____
Zoloft (sertraline) _____
Paxil (paroxetine) _____
Celexa (citalopram) _____
Lexapro (escitalopram) _____
Wellbutrin (bupropion) _____
Remeron (mirtazepine) _____
Effexor (venlafaxine) _____
Cymbalta (duloxetine) _____
Trazodone _____
Pamelor (Nortriptyline) _____
Elavil (Amitriptyline) _____
Brintellix _____
Parnate or Nardil _____
Emsam (selegiline) _____
Lithium _____
Abilify (aripiprazole) _____
Seroquel (quetiapine) _____

Zyprexa (olanzapine) _____
Buspar (buspiron) _____
Other:

Past Medical History (Prior Diagnoses made by a Physician):
_____
_____
_____
_____
_____
_____

Underline and describe if you have a history of the following:
Seizures _____
Stroke _____
Heart attack _____
Lung disease _____
Glaucoma _____
Metal in your head or eyes _____
Aneurysm clips in your brain _____
Implanted devices in brain or body _____
Pacemaker _____
Pregnancy (current or planning) _____

Hospitalizations (when/where/psychiatric or not)
_____
_____
_____
_____

History of Illnesses your Family has and who (mother, father, sibling, child):
_____
_____
_____

What county do you live?
Who do you live with?
Do you drive?
Could someone else drive for you?
Other things you think we should know about before the consult?