TMS CONSULTATION

Genesis Behavioral Health

20210410
TMS

Name: _____ **DOB:** _____ **Age:** _____ **Date:** _____

Are you ALLERGIC to any medicines? □ **No** □**Yes List:**_____

How did you hear about us? **If someone referred you, who?**

_____

□Internet □Insurance company □Friend □Therapist □Physician □ Yellow Pages □Unsure/Other _____

BACKGROUND INFORMATION

Tell us about your family & living situation

Names of those living in the same household and names of Children & Step Children *not* living with you:

□ No one lives with me. I live alone.

Living with you?	Name	Age	Relationship to you
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			

Are you married? □No □Yes
Have you ever been divorced? □No □Yes
Have you ever been remarried? □No □Yes

Educational, Work, Legal & Religious History

Occupation: _____

Education: Current or highest grade level? _____

Legal: Have you had any legal problems or ongoing problems with custody issues? □ No □ Yes
Describe:_____

Religious Beliefs

Are you a Christian? □ No □ Yes □ Unsure

Other Religious beliefs?_____

How important to you is faith in God:
□ Important □ Somewhat Important □ Not Important

Do you now or have you in the past met with others in religious or spiritual community? □No □Yes

How important is or was this to you?
□ Important □ Somewhat Important □ Not Important

THE PROBLEM WHICH BRINGS YOU HERE:

Why are you here and What are your problems/concerns?
(*Briefly explain the problem that brings you here now and what stressful circumstances have contributed to it. If you are seeking treatment with TMS/transcranial magnetic stimulation, please say why.)*

_____

_____

_____

_____

_____

_____

Rating Scales: PHQ – 9 & GAD – 7

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Rarely or Not at all	Several days (but less than half)	More than half the days	Almost every day	*PHQ-9*
DEPRESSION	**0**	**1**	**2**	**3**	
Little interest or pleasure in doing things	□	□	□	□	
Feeling down, depressed, or hopeless	□	□	□	□	
Sleep: □Trouble falling asleep □Trouble staying asleep □Sleeping too much	□	□	□	□	
Feeling tired or having little energy	□	□	□	□	
Appetite: □ Poor appetite or □ Overeating	□	□	□	□	
Feeling bad about yourself, feeling that you're a failure, or feeling that you have let yourself or your family down	□	□	□	□	
Trouble concentrating on things such as reading	□	□	□	□	Total:
Moving or speaking slowly; or being very restless, agitated	□	□	□	□	
Thinking that you would be better off dead or that you want to hurt yourself in some way	□	□	□	□	

ANXIETY	**0**	**1**	**2**	**3**	*GAD –7*
Feeling nervous, anxious, or on edge	□	□	□	□	
Not being able to stop or control worrying	□	□	□	□	
Worrying too much about different things	□	□	□	□	
Trouble relaxing	□	□	□	□	
Being so restless that it is hard to sit still	□	□	□	□	Total:
Becoming easily annoyed or irritable	□	□	□	□	
Feeling afraid as if something awful might happen or feelings of panic	□	□	□	□	

SUICIDAL THOUGHTS, ATTEMPTS, OR SELF-HARM

CURRENT THOUGHTS OF SUICIDE OR DEATH
□ I do not think of suicide or death – *if checked, skip this section*
□ No □ Yes - I feel that life is empty or wonder if it's worth living
□ No □ Yes - I have wished I were dead or wished I could go to sleep and not wake up.
□ No □ Yes - I Have been having thoughts of killing myself
□ No □ Yes - I have been thinking about how I might do this.
□ No □ Yes - I am thinking about acting on these thoughts
□ No □ Yes - I have started to work out or have worked out the details of how to kill myself.

PAST SUICIDE ATTEMPTS
□ NONE □ 1 □ 2 □ 3 or more
SELF MUTILATION
□ I have not ever hurt myself physically to distract myself from emotional pain – *if checked, may skip to next section*
□ I used to feel like cutting or hurting myself to deal with emotional pain, b t not any more
□ Recently I have felt like cutting or hurting myself
□ I think about cutting or hurting myself several times a day

RAPID MOOD SCREENER

1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed? □ No □ Yes
2. Did you have problems with depression before the age of 18? □ No □ Yes
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper? □ No □ Yes
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head? □ No □ Yes
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic? □ No □ Yes
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual? □ No □ Yes

SOCIAL ANXIETY SYMPTOMS	POST-TRAUMATIC STRESS SYMPTOMS
□ A persistent fear of being embarrassed or looking foolish,	□ You have experienced a very significant traumatic event.
especially around unfamiliar people, i.e. very shy	If YES, what?_____
□ You avoid situations in which you might be embarrassed so much	□ Distressing memories or nightmares
that it interferes significantly with your ability to function normally	□ Easily startled, always 'on guard'
	□ Feeling numb, unreal, or detached
OBSESSIVE-COMPULSIVE SYMPTOMS	□ You avoid situations reminding you of the trauma
□ Do you wash or clean a lot?	
□ Do you check things a lot?	**EATING ISSUES**
□ Is there any thought that keeps bothering you that you would like to get rid of but can't?	□ Constantly dieting despite others saying you're thin □ Binge eating or purging

PAST PSYCHIATRIC TREATMENT

Do you have a **therapist** (talk therapy)? □Yes □No Name: _____May we contact them? □Yes □No

Do you have a **psychiatrist** (MD)? □Yes □No Name: _____May we contact them? □Yes □No

Have you ever been in a psychiatric hospital or rehab facility? □No □Yes How many times? _____

MEDICAL HISTORY

Name of Primary Care Physician:_____

Have you had of any of the following: □ Diabetes
□ High Cholesterol □ High blood pressure
□ Heart Problems of any kind
□ Seizures □ Head Injury □ Loss of Consciousness

Other health issues we may need to know about:_____

_____

_____

RECENT HEALTH ISSUES (Review of Systems):
☐ Sedation/Tiredness ☐ Weight Gain/Loss ☐ Intolerance of cold
□ Headaches □ Dizziness ☐ Sweating ☐ Blurred vision ☐ Fever
□ Chronic pain; If yes, location:
□ Chest pain □ Shortness of breath □ Palpitations □ Cough
☐ GI upset/Nausea ☐ Constipation ☐ Diarrhea □ Reflux
□ Urinary hesitancy □ Visual changes □ Restless legs

FAMILY HISTORY

Please indicate whether any of your (blood) relatives have had any of these concerns:

	Grandparents	Parents	Aunts/Uncles	Brothers/Sisters	Children
Depression problems	□	□	□	□	□
Manic or Bipolar Disorder	□	□	□	□	□
Suicide	□	□	□	□	□
Anxiety and/or panic	□	□	□	□	□
Obsessive-Compulsive	□	□	□	□	□
ADHD	□	□	□	□	□
Schizophrenia	□	□	□	□	□

DEVELOPMENTAL, ABUSE, & TRAUMA HISTORY

Was your childhood: □ Basically happy □ Painful Why? _____

Were you a victim of past: □ Physical abuse? □ Neglect? □ Emotional abuse? □ Sexual abuse?

EXERCISE

In a typical week, how many times do you exercise at least 20-30 min (any type, or brisk walking or yoga)?
□ Less than once per week □ 1 time □ 2 times □ 3 times □ 4 times □ 5 times □ 6 times □ 7 times

RELATIONSHIPS AND SOCIAL SUPPORTS

PATIENT INITIALS _____

MARITAL ISSUES/ SIGNIFICANT OTHERS

Are you married? □ Yes □ No If NO, are you in a steady relationship? □ Yes □ No

How would you rate your relationship? □ Happy □ Fairly happy □ Just OK □ Fairly unhappy □ Very unhappy

OTHER CONFLICTUAL RELATIONSHIPS

□ Yes □ No Are you having significant conflict or stress with anyone other than your spouse? If so, who? _____

SOCIAL SUPPORTS

□ Yes □ No Do you experience a lot of loneliness?

□ Yes □ No Do you have a close confidant other than spouse? How often do you talk? _____

JOB

How would you rate your work satisfaction? □ Very happy □ Fairly happy □ Just OK □ Fairly unhappy □ Very unhappy

PROBLEMS WITH EMOTIONAL INSTABILITY

Problems with emotional instability – do you tend to:

□ Make frantic efforts to avoid real or imagined abandonment.

□ Have a pattern of difficult relationships caused by alternating between extremes of intense admiration and hatred of others.

□ Have an unstable self-image or be unsure of his or her own identity.

□ Act impulsively in ways that are self-damaging, such as extravagant spending, sex with many partners, substance abuse, binge eating, or reckless driving.

□ Have recurring suicidal thoughts, make repeated suicide attempts, or cause self-injury through mutilation, such as cutting or burning oneself.

□ Have frequent emotional overreactions or intense mood swings, including feeling depressed, irritable, or anxious. These mood swings may only last a few hours at a time. In rare cases, they may last a day or two.

□ Have long-term feelings of emptiness.

□ Have inappropriate, fierce anger or problems controlling anger – or often display temper tantrums or get into fights.

□ Have temporary episodes of feeling suspicious of others without reason (paranoia) or losing a sense of reality.

ALCOHOL AND SUBSTANCE USE

In the PAST 12 MONTHS, how often have you used tobacco or any other nicotine delivery product (i.e., e-cigarette, vaping or chewing tobacco)?
□ Daily or almost daily □ Weekly □ Monthly □ Less Than Monthly □ Never

In the PAST 12 MONTHS, how often have you had 5 or more drinks (men)/4 or more drinks (women) containing alcohol in one day?
□ Daily or almost daily □ Weekly □ Monthly □ Less Than Monthly □ Never

In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you?
□ Daily or almost daily □ Weekly □ Monthly □ Less Than Monthly □ Never

In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?
□ Daily or almost daily □ Weekly □ Monthly □ Less Than Monthly □ Never

In the PAST 3 MONTHS, did you smoke a cigarette containing tobacco or use any other nicotine product (i.e., e-cigarette, vaping or chewing tobacco)?
□ No □ Yes

MEDICATIONS – CURRENT and PAST MEDICATIONS

List ALL CURRENT MEDICATIONS, VITAMINS, HERBAL, & SUPPLEMENTS that you are now taking:

Medication, Vitamin, or Herbal	Medication, Vitamin, or Herbal	Medication, Vitamin, or Herbal

List ALL PAST MEDICATIONS that you have taken:

√ if Taking Now or Past	Medication Have you *ever* taken any of these:	dose	When & Why Stopped	When	√ if Taking Now or Past	Medication Have you *ever* taken any of these:	dose	When & Why Stopped	When
□Now □Past	**Ritalin/Methylin**				□Now □Past	**Abilify**			
□Now □Past	**Metadate**				□Now □Past	**Aristada or Maintenna**			
□Now □Past	**Mydayis**				□Now □Past	**Rexulti**			
□Now □Past	**Aptensio**				□Now □Past	**Geodon**			
□Now □Past	**Concerta**				□Now □Past	**Risperdal/Invega**			
□Now □Past	**Focalin (or XR)**				□Now □Past	**Zyprexa**			
□Now □Past	**Daytrana**				□Now □Past	**Seroquel (or XR)**			
□Now □Past	**Adderall (or XR)**				□Now □Past	**Saphris**			
□Now □Past	**Vyvanse**				□Now □Past	**Fanapt**			
□Now □Past	**Other stimulant**				□Now □Past	**Latuda**			
□Now □Past	**Strattera**				□Now □Past	**Vraylar**			
□Now □Past	**Clonidine**				□Now □Past	**Clozapine**			
□Now □Past	**Guanfacine**				□Now □Past	**Lithium**			
□Now □Past	**Prozac**				□Now □Past	**Depakote**			
□Now □Past	**Zoloft**				□Now □Past	**Tegretol** (Carbamazepine)			
□Now □Past	**Paxil**				□Now □Past	**Trileptal**			
□Now □Past	**Luvox**				□Now □Past	**Lamictal** (lamotrigine)			
□Now □Past	**Celexa**				□Now □Past	**Topamax**			
□Now □Past	**Lexapro**				□Now □Past	**Valium** (Diazepam)			
□Now □Past	**Effexor XR**				□Now □Past	**Xanax** (Alprazolam)			
□Now □Past	**Pristiq**				□Now □Past	**Ativan** (Lorazepam)			
□Now □Past	**Cymbalta**				□Now □Past	**Klonopin** (Clonazepam			
□Now □Past	**Wellbutrin**				□Now □Past	**Lyrica**			
□Now □Past	**Remeron**				□Now □Past	**Neurontin**			
□Now □Past	**Buspirone**				□Now □Past	**Hydroxyzine**			
□Now □Past	**Trintellix**				□Now □Past	**Ambien (or CR)**			
□Now □Past	**Viibryd**				□Now □Past	**Lunesta**			
□Now □Past	**Fetzima**				□Now □Past	**Temazepam**			
□Now □Past	**Nefazodone**				□Now □Past	**Sonata**			
□Now □Past	**Amitriptyline**				□Now □Past	**Trazodone**			
□Now □Past	**Imipramine**				□Now □Past	**Rozerem**			
□Now □Past	**EMSAM**				□Now □Past	**Melatonin**			
□Now □Past	**Nardil**				□Now □Past	**Benadryl** (antihistamine)			
□Now □Past	**Parnate**				□Now □Past	**Other OTC sleep aid**			
□Now □Past	**Ketamine**				□Now □Past	**Buprenorphine**			
□Now □Past	**Provigil/Nuvigil**				□Now □Past	**Antabuse** (disulfiram)			
□Now □Past	**Aricept** (donepezil)				□Now □Past	**Campral** (acamprosate)			
□Now □Past	**Namenda** (memantine)				□Now □Past	**Naltrexone** (oral or injectable)			