

**Genesis Behavioral Health**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Name of others with you today: Spouse/Other: Name, relationship to you: \_\_\_\_\_

When was the first time you were depressed? (best estimate)

When was the first time you were treated for depression? (best estimate)

When did this episode of depression begin? (best estimate)

What symptoms of depression are the **MOST DIFFICULT** for you?

- Low energy/motivation     Down mood     Difficulty enjoying pleasurable activities     Difficulty sleeping  
 Frequent negative thoughts (about yourself, the world, and the future)     Thoughts of not wanting to go on living

In what areas is depression affecting your ability to **function normally**?

- Work/school performance     Social Interaction     Family/Home responsibilities     Hobbies/Interests  
 Activities of daily living (examples: difficulty getting out of bed, grooming yourself as you normally do)

What **SIDE EFFECTS** have you experienced from your medications?

- Sedation/Tiredness     Anxiety     Suicidal Thoughts     Sexual Dysfunction     Insomnia     Blurred vision  
 Constipation     Headache     Weight Gain     Tremor     GI upset/Nausea     Dry mouth  
 Irritability/Anger     Sweating     Withdrawal symptoms

What **OTHER FACTORS** have contributed to your depression?

- Anxiety     Chronic pain     Medical problems     Financial stressors  
 Relationship problems     Painful childhood     Traumatic experiences     Unresolved grief

**PSYCHOTHERAPY**

Yes     No    Have you had psychotherapy for depression? What kind:  CBT     Other \_\_\_\_\_     Unsure

Approximately how many sessions? \_\_\_\_\_ When? \_\_\_\_\_

**ADDITIONAL CONSIDERATIONS FOR TMS**

- Yes     No     Unsure    Have you ever received TMS with a successful outcome? If so, when: \_\_\_\_\_
- Yes     No     Unsure    Have you received ECT (electroconvulsive therapy)?
- Yes     No     Unsure    Do you have a history of seizure disorder?
- Yes     No     Unsure    Have you had chronic psychotic symptoms, such as hallucinations present in schizophrenia?
- Yes     No     Unsure    Do you have an implanted magnetic-sensitive medical device inside your head or other implanted metal items, including but not limited to a cochlear implant, implanted cardioverter defibrillator (ICD), pacemaker, vagus nerve stimulator (VNS), or metal aneurysm clips or coils, staples, or stents. (Note: Dental amalgam fillings are not affected by the magnetic field and are acceptable for use with TMS).

Insurance:  BCBS     Cigna     Humana     Aetna     Other \_\_\_\_\_

**PAST AND CURRENT MEDICATIONS**

On the next page is a list of medications. ***IF YOU FILLED IT OUT IN THE PAST, PLEASE FILL IT OUT AGAIN.***

We understand that you may not remember the details, but just do the best you can. It is very important for us to know your past and current 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:

| <input checked="" type="checkbox"/> if Taking<br>Now or Past | Medication<br>Have you <i>ever</i> taken any of these: | dose | When & Why Stopped | When | <input checked="" type="checkbox"/> if Taking<br>Now or Past | Medication<br>Have you <i>ever</i> taken any of these: | dose | When & Why Stopped | When |
|--|--|------|--------------------|------|--|--|------|--------------------|------|
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Ritalin/Methylin</b>                                |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Abilify</b> (Aripiprazole)                          |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Metadate</b>  |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Aristada or Maintenna</b>                           |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Quillivant/Quillichew</b>                           |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Rexulti</b>   |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Aptensio</b>  |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Geodon</b> (Ziprazidone)                            |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Concerta</b> (Methylphenidate)                      |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Risperdal</b> (Risperidone)                         |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Focalin (or XR)</b><br>(dexamethylphenidate)        |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Invega</b> (Paliperidone)                           |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Daytrana</b>  |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Zyprexa</b> (Olanzapine)                            |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Adderall (or XR)</b><br>(dextroamphetamine)         |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Quetiapine</b> (Seroquel)                           |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Vyvanse</b>   |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Saphris</b>   |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Mydayis</b>   |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Fanapt</b>  |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Dyanavel</b>  |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Latuda</b>  |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Other stimulant</b>                                 |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Vraylar</b>   |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Strattera</b> (Atomoxetine)                         |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Clozapine</b>                                       |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Kapvay</b> (Clonidine)                              |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Lithium</b>   |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Intuniv</b> (Guanfacine)                            |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Depakote</b> (Valproic Acid)                        |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Prozac</b> (Fluoxetine)                             |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Tegretol</b> (Carbamazepine)                        |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Zoloft</b> (Sertraline)                             |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Trileptal</b> (Oxcarbazepine)                       |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Paxil</b> (Paroxetine)                              |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Lamictal</b> (Lamotrigine)                          |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Luvox</b> (Fluvoxamine)                             |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Topiramate</b> (Topamax)                            |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Celexa</b> (Citalopram)                             |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Valium</b> (Diazepam)                               |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Lexapro</b> (Escitalopram)                          |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Xanax</b> (Alprazolam)                              |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Effexor XR</b> (Venlafaxine)                        |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Ativan</b> (Lorazepam)                              |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Pristiq</b> (Desvenlafaxine)                        |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Klonopin</b> (Clonazepam)                           |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Cymbalta</b> (Duloxetine)                           |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Lyrica</b> (Pregabalin)                             |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Wellbutrin</b> (Bupropion)                          |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Neurontin</b> (Gabapentin)                          |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Remeron</b> (Mirtazapine)                           |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Vistaril</b> (Hydroxyzine)                          |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Buspar</b> (Buspirone)                              |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Ambien</b> (Zolpidem)                               |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Trintellix</b>                                      |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Lunesta</b> (Eszopiclone)                           |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Viibryd</b>   |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Temazepam</b>                                       |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Fetzima</b>   |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Sonata</b>  |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Nefazodone</b>                                      |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Belsomra</b>  |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Amitriptyline</b>                                   |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Trazodone</b>                                       |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Imipramine</b>                                      |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Rozerem</b>   |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>EMSAM</b>   |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Melatonin</b>                                       |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Nardil</b>  |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Benadryl</b> (antihistamine)                        |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Parnate</b>   |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Other OTC sleep aid</b>                             |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Ketamine</b>  |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Aricept</b> (donepezil)                             |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Provigil</b> (Modafanil)                            |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Namenda</b> (memantine)                             |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Nuvigil</b> (Armodafanil)                           |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Buprenorphine</b>                                   |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Prazosin</b>  |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Antabuse</b> (disulfiram)                           |      |                    |      |
| <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Naltrexone</b> (oral or injectable)                 |      |                    |      | <input type="checkbox"/> Now <input type="checkbox"/> Past   | <b>Campral</b> (acamprosate)                           |      |                    |      |