

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.

<u>Living with you?</u>	<u>Name</u>	<u>Age</u>	<u>Relationship to you</u>
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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 <u>2 weeks</u> , 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 Total: <input type="text"/>
DEPRESSION	0	1	2	3	
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep: <input type="checkbox"/> Trouble falling asleep <input type="checkbox"/> Trouble staying asleep <input type="checkbox"/> Sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Appetite: <input type="checkbox"/> Poor appetite or <input type="checkbox"/> Overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeling bad about yourself, feeling that you're a failure, or feeling that you have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble concentrating on things such as reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Moving or speaking slowly; or being very restless, agitated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thinking that you would be better off dead or that you want to hurt yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

SUICIDAL THOUGHTS, ATTEMPTS, OR SELF-HARM

<table border="1"> <thead> <tr> <th align="center">CURRENT THOUGHTS OF SUICIDE OR DEATH</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> I do <u>not</u> think of suicide or death – <i>if checked, skip this section</i></td> </tr> <tr> <td><input type="checkbox"/> No <input type="checkbox"/> Yes - I feel that life is empty or wonder if it's worth living</td> </tr> <tr> <td><input type="checkbox"/> No <input type="checkbox"/> Yes - I have wished I were dead or wished I could go to sleep and not wake up.</td> </tr> <tr> <td><input type="checkbox"/> No <input type="checkbox"/> Yes - I Have been having thoughts of killing myself</td> </tr> <tr> <td><input type="checkbox"/> No <input type="checkbox"/> Yes - I have been thinking about how I might do this.</td> </tr> <tr> <td><input type="checkbox"/> No <input type="checkbox"/> Yes - I am thinking about <u>acting</u> on these thoughts</td> </tr> <tr> <td><input type="checkbox"/> No <input type="checkbox"/> Yes - I have started to work out or have worked out the details of how to kill myself.</td> </tr> </tbody> </table>	CURRENT THOUGHTS OF SUICIDE OR DEATH	<input type="checkbox"/> I do <u>not</u> think of suicide or death – <i>if checked, skip this section</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes - I feel that life is empty or wonder if it's worth living	<input type="checkbox"/> No <input type="checkbox"/> Yes - I have wished I were dead or wished I could go to sleep and not wake up.	<input type="checkbox"/> No <input type="checkbox"/> Yes - I Have been having thoughts of killing myself	<input type="checkbox"/> No <input type="checkbox"/> Yes - I have been thinking about how I might do this.	<input type="checkbox"/> No <input type="checkbox"/> Yes - I am thinking about <u>acting</u> on these thoughts	<input type="checkbox"/> No <input type="checkbox"/> Yes - I have started to work out or have worked out the details of how to kill myself.	<table border="1"> <thead> <tr> <th align="center">PAST SUICIDE ATTEMPTS</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> NONE <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 or more</td> </tr> <tr> <td> </td> </tr> <tr> <th align="center">SELF MUTILATION</th> </tr> <tr> <td><input type="checkbox"/> I have <u>not</u> ever hurt myself physically to distract myself from emotional pain – <i>if checked, may skip to next section</i></td> </tr> <tr> <td><input type="checkbox"/> I used to feel like cutting or hurting myself to deal with emotional pain, b t not any more</td> </tr> <tr> <td><input type="checkbox"/> Recently I have felt like cutting or hurting myself</td> </tr> <tr> <td><input type="checkbox"/> I think about cutting or hurting myself several times a day</td> </tr> </tbody> </table>	PAST SUICIDE ATTEMPTS	<input type="checkbox"/> NONE <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 or more		SELF MUTILATION	<input type="checkbox"/> I have <u>not</u> ever hurt myself physically to distract myself from emotional pain – <i>if checked, may skip to next section</i>	<input type="checkbox"/> I used to feel like cutting or hurting myself to deal with emotional pain, b t not any more	<input type="checkbox"/> Recently I have felt like cutting or hurting myself	<input type="checkbox"/> I think about cutting or hurting myself several times a day
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RAPID MOOD SCREENER

1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Did you have problems with depression before the age of 18?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	<input type="checkbox"/> No <input type="checkbox"/> Yes

SOCIAL ANXIETY SYMPTOMS	POST-TRAUMATIC STRESS SYMPTOMS
<input type="checkbox"/> A persistent fear of being embarrassed or looking foolish, especially around unfamiliar people, i.e. very shy	<input type="checkbox"/> You have experienced a very significant traumatic event. If YES, what? _____
<input type="checkbox"/> You avoid situations in which you might be embarrassed so much that it interferes significantly with your ability to function normally	<input type="checkbox"/> Distressing memories or nightmares
	<input type="checkbox"/> Easily startled, always 'on guard'
	<input type="checkbox"/> Feeling numb, unreal, or detached
	<input type="checkbox"/> You avoid situations reminding you of the trauma
OBSESSIVE-COMPULSIVE SYMPTOMS	
<input type="checkbox"/> Do you wash or clean a lot?	
<input type="checkbox"/> Do you check things a lot?	EATING ISSUES
<input type="checkbox"/> Is there any thought that keeps bothering you that you would like to get rid of but can't?	<input type="checkbox"/> Constantly dieting despite others saying you're thin
	<input type="checkbox"/> 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: <input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart Problems of any kind <input type="checkbox"/> Seizures <input type="checkbox"/> Head Injury <input type="checkbox"/> Loss of Consciousness Other health issues we may need to know about: _____ _____ _____	RECENT HEALTH ISSUES (Review of Systems):
	<input type="checkbox"/> Sedation/Tiredness <input type="checkbox"/> Weight Gain/Loss <input type="checkbox"/> Intolerance of cold
	<input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Sweating <input type="checkbox"/> Blurred vision <input type="checkbox"/> Fever
	<input type="checkbox"/> Chronic pain; If yes, location: _____
	<input type="checkbox"/> Chest pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Palpitations <input type="checkbox"/> Cough
	<input type="checkbox"/> GI upset/Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Reflux
	<input type="checkbox"/> Urinary hesitancy <input type="checkbox"/> Visual changes <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manic or Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety and/or panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

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