TMS

Name:

DOB:

Allergies:

Current Interest in TMS for: (Circle One) DEPRESSION OCD

Date of onset: _____

Current Medications (please fill out entirely, estimates on doses and dates are OK)

Medication Name	Dose	Start Date

Prior Medications (please fill out entirely with any prior psychiatric medication you have taken, estimates on doses and dates are OK)

Med Name	Highest Dose	Start Date	End Date	Reason for Discontinuation

Fill out the PHQ9 screener provider and write total Score Here: _____

Fill out Becks Depression screener provided and write total Score Here: _____

Check Yes or No to the Following:

	YES	NO
Prior Adverse reaction to TMS		
Have you ever had a seizure		
Have you ever had an EKG		
Have you ever had a stroke		
Have you ever had a head injury		
Do you have any metal in your head outside of the mouth		
Any implanted devices		
Suffer from severe or frequent headaches		
Any other brain related condition		
Any illness that caused brain injury		
If female, any chance of pregnancy?		

PRIOR SURGERIES:

_____

_____

_____

_____

Are you currently seeing a therapist? (Circle One) YES NO

If yes, who are you seeing, how frequent and when did you start?

Please list ALL prior therapists including times inpatient, IOP or PHP and dates (estimates are OK)
