SOUTHERN COLORADO TMS CENTER, LLC

TREATING DEPRESSION AND OTHER ILLNESSES SINCE 2011

3225 International Circle, Suite 100 Colorado Springs, CO 80910
Phone 719-359-8812 **Fax:** 719-359-4560 **Website:** www.southerncoloradotms.com

Patient History Form

Last Name:	First Name:		Middle Initial:
Nickname:	Date of Birth:	Last 4 Social Sec #	
Address:	City:	State:	Zip:
Home #	Cell #		
Email:	May we contact you by email? ☐Yes ☐No		
Employer:	Occupation:	Work #	

Preferred Language:	Gender:	Race:	Ethnicity:

If you prefer not to answer the above 4 questions, please initial here: _____

Emergency Contact Information:

Name:		Relationship:	
Address:	City:	State:	Zip:
Home #:	Cell #:	Email:	

Referring Professional Information:

Name:		Phone #:	
Address:	City:	State:	Zip:

Additional Providers:

Current Psychiatrist's Name:	
Phone #:	Date of last visit:

Current Psychotherapist's Name:	
Phone #:	Date of last visit:

Current Primary Care Physician's Name:	
Phone #:	Date of last visit:

Insurance Information:

Insurance Company:	
Subscriber's Name:	Subscriber's Date of Birth:
ID#:	Group ID#:

My primary problems are (numbered in order of importance to me) :

	Depression		Anxiety		Personality Disorder
	Bipolar		OCD		Migraines
	ADD/ADHD		Tinnitus		Other _____

On a scale of ONE (very little relief) to TEN (almost complete relief), the impact of my current treatments, including medication, on my depression has been: _____

On a scale of ONE (very little disruption of my life) to TEN (completely disruptive of my life), my depression on most days averages: _____

The current episode of the #1 problem I listed above began _____ years ago.

The triggering event for my current episode was (your best guess): _____

On a scale of 0 to 10, with 10 the worst, my #1 problem listed above on most days averages:_____

The last time I felt good was _____ years ago.

I was first diagnosed by a doctor with Depression at age _____.

Do you have suicidal thoughts or feelings? _____Yes _____No

My earliest thoughts about suicide occurred at age _____.

Have you ever attempted suicide? ____Yes ____No

Number of attempts: _____ Date of attempt(s)_____

Please rate on a 1-3 scale how true each statement has been for you during the last week:
(With 1 being true, 2 somewhat true and 3 is false)

There is no one I can depend on	
It seems as if I can do nothing right	
Everything I do turns out wrong	
The people I care the most for are gone	
I have been having thoughts of killing myself	
I have thoughts about how I might kill myself	
I have a plan to kill myself	

Psychotherapy:

Are you currently in psychotherapy? _____Yes ____No

Provider's Name: _____ Phone #: _____

How long have you been seeing them? _____ What type of therapy? _____

Have you received psychotherapy in the past? ____Yes ____No

Provider's Name: _____ Phone #: _____

How long did you see them? _____ What type of therapy? _____

Psychiatric Hospitalizations: _____ Not Applicable

Date: _____ # of Days: _____ Hospital: _____

Date: _____ # of Days: _____ Hospital: _____

MEDICATION ALLERGIES: _____

Current Medications:

Please list **ALL** medications, herbal vitamins, & supplements you currently take for any reason.

Medication Name:	**Dosage:** mg, mcg,	**Instructions:** one daily, one twice daily, ect.	**How long have you taken medication:**

Side Effects: What side effects, if any, are you **currently** experiencing from anti-depressant medications?

☐ nausea	☐ weight gain	☐ decreased sexual interest
☐ fatigue	☐ skin rash	☐ sexual dysfunction
☐ insomnia	☐ dry mouth	☐ blurred vision
☐ constipation	☐ dizziness	☐ anxiety
☐ restlessness	☐ diarrhea	☐ urinary retention
☐ agitation	☐ headaches	☐ confusion
☐ rapid heart beats	☐ other: _____	☐ other: _____

On a ONE (very mild) to TEN (unbearable) scale, side effects from current medications are: _____

History of Medications:

Record each medication you have taken in the past for your **depression**. It is VERY important to provide details of dose and duration. Your insurance carrier's cooperation depends on these details. You can contact your current or past pharmacy and request a printed complete list.

Medication Name:	**Max Dosage:** mg, mcg,	**How long taken?**	**Side effects? Stopped working?**

Please let us know if you are currently using or have used within the past five years:

☐ cigarettes	☐ marijuana	☐ heroin
☐ chew	☐ speed	☐ huff gases
☐ alcohol	☐ pain killers	☐ cocaine
☐ other _____	☐ other _____	☐ other _____

YES	NO	If you answer YES to any question fully describe answer.
☐	☐	Do you have a cardiac pacemaker / defibrillator?
☐	☐	Do you have an aneurysm clip?
☐	☐	Do you have a vagal nerve stimulator?
☐	☐	Do you have a cochlear implant?
☐	☐	Do you have any other implanted device?
☐	☐	Do you have any metallic objects in your body or head?
☐	☐	Have you ever had brain surgery?
☐	☐	Have you ever been knocked unconscious, have fainting spells or syncope?
☐	☐	Do you have tattoos on your face, neck or scalp?
☐	☐	Do you have permanent lip or eye liner?
☐	☐	Do you have any hearing problems or ringing in your ears?
☐	☐	Are you pregnant or think you could be pregnant?
☐	☐	Do you have cancer?
☐	☐	Do you have headaches?
☐	☐	Have you ever had a seizure? If yes: Date_____
☐	☐	Have you ever suffered a stroke / TIA? If yes: Date_____
☐	☐	Do you have any cardiac disease?
☐	☐	Do you have any infectious disease?
☐	☐	Do you have a medication infusion device?
☐	☐	Have you ever had an MRI of your brain? If yes: Date_____
☐	☐	Do you have any other medical problems? (past or present)
☐	☐	Have you had ECT? If yes: Date _____ Outcome:_____
☐	☐	Have you had TMS before? If yes: Date _____ Outcome:_____
☐	☐	Have you had an EEG before? If yes: Date _____ Outcome:_____
☐	☐	Have you suffered abuse? If yes: physical / emotional/ sexual
☐	☐	Have you ever used a Light Box? _____ Are you using one now? _____
☐	☐	Have you ever had Neurofeedback?

Please check the box below if you feel the following statements are true:

☐ I believe I have a problem with alcohol or drugs.
☐ Other people have annoyed me by criticizing my drinking/drug use.
☐ At times, I've thought I should cut down on my drinking/drug use.
☐ I have sometimes felt bad or guilty about my drinking/drug use.
☐ Sometimes I take a drink first thing in the morning to steady my nerves or to get rid of a hangover.
☐ It is hard for me to get through some days without using recreational drugs.
☐ Other people think I have a problem with alcohol or drugs.

****Do you currently smoke tobacco? _____**

****Are you Right or Left Handed? _____**

ANTIDEPRESSANTS

NAME BRAND	GENERIC NAME	CLASSIFICATION
Celexa	citalopram	SSRI
Lexapro	escitalopram	SSRI
Luvox	fluvoxamine	SSRI
Paxil	paroxetine	SSRI
Prozac	fluoxetine	SSRI
Zoloft	sertraline	SSRI
Wellbutrin, Forvivo	bupropion	DRI
Cymbalta	duloxetine	SNRI
Effexor	venlafaxine	SNRI
Fetzima	levomilnacipran	SNRI
Pristiq	desvenlafaxine	SNRI
Savella	milnacipran	SNRI
Desyrel	trazodone	Tricyclic
Anafranil	clomipramine	Tricyclic
Elavil	amitriptyline	Tricyclic
Norpramin	desipramine	Tricyclic
Pamelor, Aventyl	nortriptyline	Tricyclic
Sinequan	doxepin	Tricyclic
Surmontil	trimipramine	Tricyclic
Vivactil	protriptyline	Tricyclic
Tofranil	imipramine	Tricyclic
Asendin	amoxapine	Tetracyclic
Ludiomil	maprotiline	Tetracyclic
Remeron	mirtzapine	AtypNorSer
Serzone	nefazodone	AtypNorSer
Brintellix, Trintellix	vortioxetine	AtypRecBind
Viibryd	vilazodone	AtypSer
EMSAM	selegiline	MAOI
Marplan	isocarboxazid	MAOI
Nardil	phenelzine	MAOI
Parnate	tranylcypromine	MAOI
Symbyax	olanz/fluox	Combination
Ketalar	ketamine	NMDA

AUGMENTERS

NAME BRAND	GENERIC NAME	CLASSIFICATION
Eskalith, Lithobid	lithium	mood stabilizer
Lamictal	lamotrigine	mood stabilizer
Topamax	topiramate	mood stabilizer
Abilify	aripiprazole	atypical
Clozaril	clozapine	atypical
Fanapt	iloperidone	atypical
Geodon	ziprazadone	atypical
Invega	paliperidone	atypical
Latuda	lurasidone	atypical
Risperdal	risperidone	atypical
Rexulti	brexpiprazole	atypical
Saphris	asenapine	atypical
Seroquel	quetiapine	atypical
Vraylar	cariprazine	atypical
Zyprexa	olanzapine	atypical
Orap	pimozide	typical ap
Deplin, Cerefolin	L-methylfolate	essential vitamin
Omega 3's	fish oils	essential fatty acids
Creatine		supplement
SAMe		supplement
Inositol	inositol	supplement
Symmetrel	amantadine	dopamine agonist
Mirapex	pramipexole	dopamine agonist
Visken	pindolol	B- adrenergic antagonist
BuSpar	buspirone	azapirone
Cytomel	Thyroid T3	hormones
Levothyroxine	Thyroid T4	hormones
Estrogen	estrogen	hormones
Testosterone	androgen	hormones
Adderall	D+L amphetamine	stimulants
Cylert	pemoline	stimulants
Desoxyn	methamphetamine	stimulants
Dexedrine	d-amphetamine	stimulants
Nuvigil	armodafanil	stimulants
Provigil	modafanil	stimulants
Ritalin, many others	methylphenidate	stimulants
Strattera	atomoxetine	stimulants
Vyvannse	lisdexamfetamine	stimulants

Beck Depression Inventory

Name:_____ Date:_____

Marital Status:_____ Age:_____ Gender:_____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeing during the **PAST TWO WEEKS, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group area and be sure you do not choose more than one statement for any group, including ITEM 16 (Changes in Sleeping Pattern) or ITEM 18 (Changes in Appetite).

1. Sadness 0. I do not feel sad. 1. I feel sad much of the time. 2. I am sad all the time. 3. I am so sad or unhappy that I can't stand it.	6. Self-Dislike 0. I feel the same about myself as ever. 1. I have lost confidence in myself. 2. I am disappointed in myself. 3. I dislike myself.
2. Past Failure 0. I do not feel like a failure. 1. I have failed more than I should have. 2. As I look back, I see a lot of failures. 3. I feel I am a total failure as a person.	7. Self-Criticalness 0. I don't criticize or blame myself more than usual. 1. I am more critical of myself than I used to be. 2. I criticize myself for all my faults. 3. I blame myself for everything bad that happens.
3. Loss of Pleasure 0. I get as much pleasure as I ever did from the things I enjoy. 1. I don't enjoy things as much as I used to. 2. I get very little pleasure from things I used to enjoy. 3. I can't get any pleasure from things I used to enjoy.	8. Pessimism 0. I am not discouraged about my future. 1. I feel more discouraged about my future than I used to be. 2. I do not expect things to work out for me. 3. I feel my future is hopeless and will only get worse.
4. Agitation 0. I am no more restless or wound up than usual. 1. I feel more restless or wound up than usual. 2. I'm so restless or agitated that it's hard to stay still. 3. I am so restless or agitated that I have to keep moving or doing something.	9. Guilty Feelings 0. I don't feel particularly guilty. 1. I feel guilty over many things I have done or should have done. 2. I feel guilty most of the time. 3. I feel guilty all the time.
5. Punishment Feelings 0. I don't feel I am being punished. 1. I feel I may be punished. 2. I expect to be punished. 3. I feel I am being punished.	10. Crying 0. I don't cry anymore than I used to. 1. I cry more than I used to. 2. I cry over every little thing. 3. I feel like crying, but I can't.

OFFICE USE ONLY:

SUBTOTAL PAGE ONE:_____

SUBTOTAL PAGE TWO:_____

TOTAL SCORE:_____

11. Loss of Interest 0. I have not lost interest in other people or my activities. 1. I am less interested in other people or things than before. 2. I have lost most of my interest in other people or things. 3. It's hard to get interested in anything.	17. Worthlessness 0. I do not feel I am worthless. 1. I don't consider myself as worthwhile or useful as I used to. 2. I feel more worthless as compared to other people. 3. I feel utterly worthless.
12. Indecisiveness 0. I make decisions about as well as ever. 1. I find it more difficult to make decisions than usual. 2. I have much greater difficulty in making decisions than I used to. 3. I have trouble making any decisions.	18. Tiredness of Fatigue 0. I am no more tired or fatigued than usual. 1. I get tired or fatigued more easily than usual. 2. I am too tired or fatigued to do a lot of the things I used to. 3. I am too tired or fatigued to do most of the things I used to.
13. Loss of Energy 0. I have as much energy as ever. 1. I have less energy than I used to have. 2. I don't have enough energy to do very much. 3. I don't have enough energy to do anything.	19. Irritability 0. I am no more irritable than usual. 1. I am more irritable than usual. 2. I am much more irritable than usual. 3. I am irritable all the time.
14. Changes in Sleeping Pattern 0. I have not experienced any change in my sleeping pattern. 1.a. I sleep somewhat more than usual. 1.b. I sleep somewhat less than usual. 2.a. I sleep a lot more than usual. 2.b. I sleep a lot less than usual. 3.a. I sleep most of the day. 3.b. I wake up one-two hours early and can't get back to sleep.	20. Changes in Appetite 0. I have not experienced any change in appetite. 1.a. My appetite is somewhat less than usual. 1.b. My appetite is somewhat greater than usual. 2.a. My appetite is much less than before. 2.b. My appetite is much greater than usual. 3.a. I have no appetite at all. 3.b. I crave food all the time.
15. Concentration Difficulties 0. I can concentrate as well as ever. 1. I can't concentrate as well as usual. 2. It's hard to keep my mind on anything for very long. 3. I find I can't concentrate on anything.	21. Loss of Interest in Sex 0. I have not noticed any recent changes in my interest in sex. 1. I am less interested in sex than I used to be. 2. I am much less interested in sex now. 3. I have lost interest in sex completely.
16. Suicidal Thoughts or Wishes 0. I don't have any thoughts of killing myself. 1. I have thoughts of killing myself, but I would not carry them out. 2. I would like to kill myself. 3. I would kill myself if I had the chance.	

PATIENT NAME _____ TODAY'S DATE _____

PHQ-9 Over the **last 2 weeks**, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people? [ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ]Extremely difficult					
TOTAL PHQ-9 SCORE + Q=					

GAD-7 Over the **last 2 weeks**, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people? [ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ]Extremely difficult					
TOTAL GAD-7 SCORE + Q=					

NAME: _____ DATE: _____

Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF)

Taking everything into consideration, during the past week how satisfied have you been with your …

	Very Poor	Poor	Fair	Good	Very Good
physical health?					
mood?					
work?					
household activities?					
social relationships?					
family relationships?					
leisure time activities?					
ability to function in daily life?					
sexual drive, interest and/or performance?**					
economic status?					
living/housing situation? **					
ability to get around physically without feeling dizzy, unsteady or falling? **					
your vision in terms of ability to do work or hobbies? **					
overall sense of well being?					
medication? (If not taking any, check here ___ and leave item blank.)					
How would you rate your overall life satisfaction and contentment during the past week?					

** If satisfaction is very poor, poor or fair on these items, please <u>UNDERLINE</u> the factor(s) associated with a lack of satisfaction.