TRUE NORTH TMS
AT WILLOW MEDICAL

Name: _____ Date of Birth: _____ Date: _____

Please complete all information on this form and bring it to the first office visit. It may seem long, but most of the questions require only a check. You may need to ask family members about the family history.

Primary Care Physician: _____ Current Counselor: _____

Current Psychiatrist: _____

What are the problem(s) you are seeking help for?_____

_____

Current major life stressors: _____

What are your treatment goals? _____

Current Symptoms Checklist: (check once for any symptoms present)

☐Depressed mood	☐Worthlessness/excessive guilt	☐Crying spells
☐Lack of pleasure	☐Decreased ability to think/concentrate/indecisiveness	☐Hopelessness/Helplessness
☐Weight loss/gain	☐Recurrent thoughts of death/suicidal ideation	☐No motivation
☐Sleep disturbances	☐Homicidal ideation	☐Seasonal component
☐Fatigue/loss of energy		☐Decreased libido

When were you diagnosed with depression: _____

Duration of your current episode of depression: _____

☐Mania/hypomania	☐Elevated self-esteem	☐Increased risk-taking behavior
☐Significant mood swings	☐Increased irritability	☐Decreased need for sleep
☐Elevated mood	☐Increased impulsivity	☐Hyper talkative
☐Racing thoughts	☐Increased goal directed activity	☐Grandiose thinking

Frequency of manic/hypomanic episode: _____

☐Auditory or visual hallucinations ☐Paranoid thinking

☐Suspicious of other

☐Anxiety

☐Worry about: _____

☐Panic episodes - Lasts for how long: _____Occurs every: _____

☐Obsessive thoughts ☐Compulsive behaviors (checking/counting)

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☐Nightmare/flashbacks ☐Fears of social situations

☐Specific fears:_____

☐Problems with attention ☐Hyperactivity

☐Inattention ☐Impulsivity

Current Medications: List ALL current prescription medications: _____

_____

_____

List ALL current over the counter medications or supplements: _____

_____

Allergies: _____

Current Medical Problems:_____

_____

Past Psychiatric History: Outpatient treatment: ☐ Yes ☐ No Where/when/reason:

_____

Inpatient treatment: ☐ Yes ☐ No Where/when/reason:

_____

Prior treatment with: ☐ TMS ☐ ECT ☐ Other: _____

Any suicide attempts: ☐ Yes ☐ No When: _____

Past Psychiatric Medications: Please list the dosage, date, response, and side effects associated:

SSRIs		Dosage	Date	Response	Side Effects
Prozac (fluoxetine)	☐				
Paxil (paroxetine)	☐				
Zoloft (sertraline)	☐				
Celexa (citalopram)	☐				
Lexapro (escitalopram)	☐				
Luvox (fluvoxamine)	☐				
SNRIs					
Effexor (venlafaxine)	☐				
Cymbalta (duloxetine)	☐				
Pristiq (desvenlafaxine)	☐				

Fetzima (levomilnacipran)	☐				
Other					
Wellbutrin (bupropion)	☐				
Remeron (mirtazapine)	☐				
TCAs/TeCAs					
Anafranil (clomipramine)	☐				
Pamelor (nortptyline)	☐				
Tofranil (imipramine)	☐				
Elavil (amitriptyline)	☐				
Vivactil (protriptyline)	☐				
Serotonin Modulators					
Viibryd (vilazodone)	☐				
Serzone (nefazodone)	☐				
Trintellix (vortioxetine)	☐				
MAOIs					
Emsam (selegiline)	☐				
Parnate (tranylcypromine)	☐				
Nardil (phenelzine)	☐				
Mood Stabilizers					
Tegretol (carbamazepine)	☐				
Trileptal (oxcarbazepine)	☐				
Lithium	☐				
Depakote (valproate)	☐				
Lamictal (lamotrigine)	☐				
Neurontin (gabapentin)	☐				
Topamax (topiramate)	☐				
Antipsychotics / Mood Stabilizers					
Haldol (haloperidol)	☐				
Clozaril (clozapine)	☐				
Zyprexa (olanzapine)	☐				
Seroquel (quetiapine)	☐				
Risperdal (risperidone)	☐				
Abilify (aripiprazole)	☐				
Geodon (ziprasidone)	☐				
Saphris (asenapine)	☐				
Latuda (lurasidone)	☐				
Rexulti (brexpiprazole)	☐				
Vraylar (cariprazine)	☐				
Fanapt (iloperidone)	☐				
Invega (paliperidone)	☐				
Sedative/Hypnotics					

Ambien (zolpidem)	☐				
Sonata (zaleplon)	☐				
Lunesta (eszopidone)	☐				
Rozerem (ramelteon)	☐				
Restoril (temazepam)	☐				
Desyrel (trazodone)	☐				
Belsomra (suvorexant)	☐				
ADHD Medications					
Ritalin (methylphenidate)	☐				
Concerta (methylphenidate)	☐				
Focalin (dexmethylphenidate)	☐				
Dexedrine (dextroamphetamine)	☐				
Vyvanse (lisdexamfetamine)	☐				
Adderall (amphetamine)	☐				
Strattera (atomoxetine)	☐				
Intuniv (guanfacine)	☐				
Antianxiety medications					
Xanax (alprazolam)	☐				
Xanax XR	☐				
Ativan (lorazepam)	☐				
Klonopin (clonazepam)	☐				
Valium (diazepam)	☐				
Tranxene (clorazepate)	☐				
Buspar (buspirone)	☐				
Other	☐				
	☐				
	☐				

Personal psychiatric history:

☐Depression ☐Schizophrenia ☐Substance Abuse

☐Bipolar ☐ADHD ☐Suicide

☐Anxiety ☐Developmental/LD

☐OCD ☐Eating Disorder

Personal medical history:

☐Seizures ☐Diabetes ☐Cancer

☐Thyroid Disorder ☐Heart Disease ☐Head Injury with LOC/Concussion

☐Seizures
☐Stroke
☐Hypertension
☐Cardiovascular Disease
☐Arrhythmias
☐Sleep Disorder
☐Endocrine
☐Pulmonary
☐Musculoskeletal Disorder
☐GI/Liver Disease
☐Renal Disease
☐Anemia, Coagulation Disorder
☐Pregnant

Date of last Physical Exam: _____

Past Surgeries:

_____

_____

Other Medical Information for TMS: Magnetic-sensitive metal in their head or within 12 inches (30 cm) of the NeuroStar magnetic coil that cannot be removed

☐Cochlear implants
☐Aneurysm clips or coils
☐Stents
☐Electrodes to monitor your brain activity
☐Ferromagnetic implants in your ears or eyes
☐Bullet fragments
☐Other metal devices/objects implanted in the head
☐Facial Tattoos/Permanent makeup

Implanted stimulators in or near the head:

☐Deep brain stimulators
☐Cochlear implants,
☐Vagus nerve stimulators

Family psychiatric history:

☐Depression
☐Bipolar
☐Anxiety
☐OCD
☐Schizophrenia
☐ADHD
☐Developmental/LD
☐Eating Disorder
☐Substance Abuse
☐Suicide

Family medical history:

☐Seizures
☐Thyroid Disorder
☐Diabetes
☐Heart Disease
☐Cancer
☐Head Injury with LOC/Concussion
☐Seizures
☐Stroke
☐Hypertension
☐Cardiovascular Disease
☐Arrhythmias

☐Sleep Disorder

☐Endocrine

☐Pulmonary

☐Musculoskeletal Disorder

☐GI/Liver Disease

☐Renal Disease

☐Anemia, Coagulation Disorder

☐Other:

Substance Use:

☐Tobacco

Amount:

☐Caffeine

Amount:

☐Marijuana

☐Sedative/Hypnotics

☐Stimulants

☐Alcohol

Amount:

☐Black Out

☐Withdrawals

☐Seizures

☐Delirium Temens

☐DUIs

☐IV Drug Use/illicit drug use

☐Cocaine/Amphetamines

☐Opiates

☐Others

Have you even felt you ought to cut down on your drinking or drug use: ☐Yes ☐No

Have people criticized your drinking or drug use: ☐Yes ☐ No

Have you felt guilty about your drinking or drug use: ☐ Yes ☐No

Have you ever had a drink/used drugs in the morning to steady your nerve/ rid a hangover: ☐ Yes ☐ No

Have you been treated for alcohol or drug use: ☐Yes ☐No

If yes, which substance: _____

Where and when were you treated: _____

Family Background and Childhood History: Where were you born and raised: _____

_____

Father's occupation: _____ Mother's occupation: _____

Sibling's gender/ages:_____

Did your parent divorce: ☐ Yes ☐ No How old were you when they divorced: _____

If your parents divorced, who did you live with: _____

Education History: Did you enjoy school: _____ How far in school did you go: _____

_____

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Has anyone in your immediate family died: ☐ Yes ☐ No Who/When: _____

Trauma History: Do you have a history of being mistreated emotionally, sexually, physically, or neglected: ☐ Yes ☐ No

Relationship History and Current Family:

Are you currently: ☐Married ☐Divorced ☐Single ☐ Widowed How long: _____

If not married are you currently in a relationship: ☐ Yes ☐ No How long: _____

Do you have any children: ☐ Yes ☐ No Gender/ages of children: _____

_____

Describe your relationship with your spouse/children: _____

_____

List everyone who currently lives with you: _____

_____

Occupational History: Are you currently working: ☐ Working ☐ Unemployed by choice☐ unemployed ☐ Disabled☐ Retired

How long in present position: _____ What is/was your occupations: _____

Where do you work: _____

Served in the military: ☐ Yes ☐No What branch and when: _____

Spiritual Life: Do you belong to a religion or spiritual group: ☐ Yes ☐ No

Primary Support: _____

Legal: Have you ever been arrested:☐ Yes ☐ No

Do you have any pending legal problems: ☐ Yes ☐ No

Any history of DUI's or public intoxications: ☐ Yes ☐ No

Signature: _____ Date: _____