Patient Name: ______________________________ D.O.B. ____________________

TMS WASHINGTON

Current Medications

Medication	Dosage	Medication Start Date	Effect

TMS WASHINGTON

Patient Name: ___________________________ D.O.B. __________________

Historical Medications

Please note that insurance will need ALL details of current and past medications to approve treatment.

SSRIs

☐ Citalopram (Celexa)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Escitalopram (Lexapro)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Fluoxetine (Prozac)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Fluvoxamine (Luvox)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Paroxetine (Paxil)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Sertraline (Zoloft)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Vilazodone (Viibryd)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Vortioxetine (Trintellix)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

SNRIs

☐ Desvenlafaxine (Pristiq)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Duloxetine (Cymbalta)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Levomilnacipran (Fetzima)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

Patient Name: ____________________________ D.O.B. __________________

☐ Milnacipran (Savella)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Venlafaxine (Effexor)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

TCAs

☐ Amitriptyline (Elavil)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Clomipramine (Anafranil)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Doxepin (Silenor)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Imipramine (Tofranil)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Nortriptyline (Pamelor)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

MAOI

☐ Phenelzine (Nardil)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Tranylcypromine (Parnate)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

Other

☐ Adderall

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Alprazolam (Xanax)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

Patient Name: ____________________________ D.O.B. __________________

☐ Aripiprazole (Abilify)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Atomoxetine (Strattera)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Bupropion (Wellbutrin)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Buspirone (Buspar)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Clonazepam (Klonopin)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Diazepam (Valium)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Eszopiclone (Lunesta)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Gabapentin (Gralise)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Lamotrigine (Lamictal)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Lisdexamfetamine (Vyvanse)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Lithium

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ L-methylfolate (Enlyte)

Date Range: ___/___/___ to ___/___/____ Dosage: __________ Was it successful? ☐ yes ☐ no
List any side effects:____

Patient Name: ______________________________ D.O.B. ____________________

☐ Lorazepam (Ativan)

Date Range: ___/___/___ to ___/___/____ Dosage: ___________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Methylphenidate (Ritalin/Concerta)

Date Range: ___/___/___ to ___/___/____ Dosage: ___________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Mirtazapine (Remeron)

Date Range: ___/___/___ to ___/___/____ Dosage: ___________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Olanzapine (Zyprexa)

Date Range: ___/___/___ to ___/___/____ Dosage: ___________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Quetiapine (Seroquel)

Date Range: ___/___/___ to ___/___/____ Dosage: ___________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Risperidone (Risperdal)

Date Range: ___/___/___ to ___/___/____ Dosage: ___________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Temazepam (Restoril)

Date Range: ___/___/___ to ___/___/____ Dosage: ___________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Trazodone (Desyrel)

Date Range: ___/___/___ to ___/___/____ Dosage: ___________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Ziprasidone (Geodon)

Date Range: ___/___/___ to ___/___/____ Dosage: ___________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Zolpidem (Ambien)

Date Range: ___/___/___ to ___/___/____ Dosage: ___________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Other

Date Range: ___/___/___ to ___/___/____ Dosage: ___________ Was it successful? ☐ yes ☐ no
List any side effects:____

☐ Other

Date Range: ___/___/___ to ___/___/____ Dosage: ___________ Was it successful? ☐ yes ☐ no
List any side effects:____

Patient Name: ___________________________ D.O.B. __________________

Extra medication notes:

____

____

____

Psychiatric Hospitalizations: ☐ Not applicable

Date: _____________ # of Days: ________ Hospital: ____________________________________

Reason: ____

Date: _____________ # of Days: ________ Hospital: ____________________________________

Reason: ____

Suicide Attempts:

Have you ever attempted suicide? ☐Yes ☐ No

# of Attempts: _______ Date(s) of attempt(s): ____

Previous Electroconvulsive Therapy (ECT): ☐ Not applicable

Date: _____________ # of treatments: ________ Hospital: ______________________________

Previous TMS Treatment: ☐ Not applicable

Date: _____________ # of treatments: ________ Location:_______________________________

Effect:____

Psychotherapy:

* Please note that insurance will need ALL details of current and past psychotherapy to approve treatment.

Are you currently in psychotherapy? ☐Yes ☐ No

Date started: __________ How often? ☐ Weekly ☐ bi-weekly ☐ monthly ☐ other _______

Type: ☐ CBT ☐ DBT ☐ Psychoanalysis ☐ Integrative ☐ Holistic ☐ Talk Therapy

Name of therapist/clinic: ________________________________For how long? ______________

Have you received psychotherapy in the past? ☐Yes ☐ No

Date started: __________ How often? ☐ Weekly ☐ bi-weekly ☐ monthly ☐ other _______

Type: ☐ CBT ☐ DBT ☐ Psychoanalysis ☐ Integrative ☐ Holistic ☐ Talk Therapy

Name of therapist/clinic: ________________________________For how long? ______________

Was it helpful? ☐Yes ☐ No

Patient Name: ___________________________ D.O.B. __________________

Transcranial Magnetic Stimulation Adult Safety Screen (TASS)

Question	Response
1. Have you ever had an adverse reaction to rTMS?	☐ No ☐ Yes
2. Have you ever had a seizure?	☐ No ☐ Yes
3. Have you ever had an EEG?	☐ No ☐ Yes
4. Have you ever had a stroke?	☐ No ☐ Yes
5. Have you ever had a head injury (including neurosurgery)?	☐ No ☐ Yes
6. Do you have any metal in your head (outside of the mouth) such as shrapnel, surgical clips, or fragments from welding or metal work?	☐ No ☐ Yes
7. Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intracardiac lines?	☐ No ☐ Yes
8. Do you suffer from frequent or severe headaches?	☐ No ☐ Yes
9. Have you ever had any other brain-related condition?	☐ No ☐ Yes
10. Have you ever had any illness that caused brain injury?	☐ No ☐ Yes
11. Are you taking any medications?	☐ No ☐ Yes
12. If you are woman of childbearing age, are you sexually active, and if so, are you *not using* a reliable method of birth control?	☐ No ☐ Yes
13. Does anyone in your family have epilepsy?	☐ No ☐ Yes
14. Do you need further explanation of rTMS and its associated risks?	☐ No ☐ Yes

If any item was marked 'yes', pleased provide comment/explanation here:

Patient signature: ____ Date: ___________