INSTITUTE FOR ADVANCED PSYCHIATRY

TRANSCRANIAL MAGNETIC STIMULATION & BRAIN MUSIC THERAPY

TMS - DEPRESSION HISTORY

Date: _____ Patient Name:_____DOB:_____

How did you hear about TMS? _____

What do you know about TMS? _____

Referring Physician? _____ Name of Practice:_____

Name of Inpatient Treatment for Depression:_____

Total Days Spent: _____ Dates of Stay:_____

Name of Inpatient Treatment for Depression:_____

Total Days Spent: _____ Dates of Stay:_____

Name of Outpatient Treatment for Depression:_____

Total Days Spent: _____ Dates of Stay:_____

Name of Outpatient Treatment for Depression:_____

Total Days Spent: _____ Dates of Stay:_____

Name of Facility for ECT Treatment:_____ Total Sessions:_____

Dates of Treatment: _____ Response to ECT Treatment: None Partial Remission

Name of Facility for TMS Treatment:_____ Total Sessions:_____

Dates of Treatment: _____ Response to TMS Treatment: None Partial Remission

Other Treatments for Depression: (date, type of treatment, effectiveness)

_____

_____

_____

Check All That Apply:

	Head Trauma		Fainting		Chronic Pain		Aneurysm Clips/Coils		Implanted Electrodes		Metal Devices/Objects
	Seizures		Headaches		Pacemaker		Stents		Ferromagnetic Implants		Tattoos
	Dizziness		Migraines		Aneurysm		Implanted Stimulators		Bullet Fragments		Dental Implants

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Psycotherapy/Counseling

Therapist Name:________________________________ Frequency of Appointments: (weekly, biweekly, monthly, etc.)__________

Dates Seen:_________________ - ____________________ Outcome/Did It Help?: Yes No

Therapist Name:________________________________ Frequency of Appointments: (weekly, biweekly, monthly, etc.)__________

Dates Seen:_________________ - ____________________ Outcome/Did It Help?: Yes No

Therapist Name:________________________________ Frequency of Appointments: (weekly, biweekly, monthly, etc.)__________

Dates Seen:_________________ - ____________________ Outcome/Did It Help?: Yes No

Therapist Name:________________________________ Frequency of Appointments: (weekly, biweekly, monthly, etc.)__________

Dates Seen:_________________ - ____________________ Outcome/Did It Help?: Yes No

Therapist Name:________________________________ Frequency of Appointments: (weekly, biweekly, monthly, etc.)__________

Dates Seen:_________________ - ____________________ Outcome/Did It Help?: Yes No

<u>CURRENT</u> Psychiatric Medications Taken

Dates:________-________ Time Taken:_________ Medication:____ Dose:_________

Effectiveness:______________________________ Side-effect:____

Dates:________-________ Time Taken:_________ Medication:____ Dose:_________

Effectiveness:______________________________ Side-effect:____

Dates:________-________ Time Taken:_________ Medication:____ Dose:_________

Effectiveness:______________________________ Side-effect:____

Dates:________-________ Time Taken:_________ Medication:____ Dose:_________

Effectiveness:______________________________ Side-effect:____

Dates:________-________ Time Taken:_________ Medication:____ Dose:_________

Effectiveness:______________________________ Side-effect:____

Dates:________-________ Time Taken:_________ Medication:____ Dose:_________

Effectiveness:______________________________ Side-effect:____

Dates:________-________ Time Taken:_________ Medication:____ Dose:_________

Effectiveness:______________________________ Side-effect:____

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Check Each Treatments You Have Had IN THE PAST (not currently taken)

	Dates Taken	Dose	Effective?	List Side Effects
_____ **Celexa (Citalopram)**	_____-_____	_____	___Y ___N	_____
_____ **Lexapro (Escitalopram)**	_____-_____	_____	___Y ___N	_____
_____ **Luvox (Fluvoxamine)**	_____-_____	_____	___Y ___N	_____
_____ **Paxil (Fluoxetine)**	_____-_____	_____	___Y ___N	_____
_____ **Viibryd (vilazodone)**	_____-_____	_____	___Y ___N	_____
_____ **Geodon (Ziprasidone)**	_____-_____	_____	___Y ___N	_____
_____ **Invega (Paliperidone)**	_____-_____	_____	___Y ___N	_____
_____ **Latuda (Lurisadone)**	_____-_____	_____	___Y ___N	_____
_____ **Risperdal (Risperidone)**	_____-_____	_____	___Y ___N	_____
_____ **Saphris (Asenapine)**	_____-_____	_____	___Y ___N	_____
_____ **Seroquel (Quetapine)**	_____-_____	_____	___Y ___N	_____
_____ **Zyprexa (Olanzapine)**	_____-_____	_____	___Y ___N	_____
_____ **Haldol (Haloperidol)**	_____-_____	_____	___Y ___N	_____
_____ **Mellaril (Thioridazie)**	_____-_____	_____	___Y ___N	_____
_____ **Thorazine (Chlorpromazine)**	_____-_____	_____	___Y ___N	_____
_____ **Trilafon (Perphenazine)**	_____-_____	_____	___Y ___N	_____
_____ **Adderall (d/l amphetamine)**	_____-_____	_____	___Y ___N	_____
_____ **Dexadrine (d-amphetamine)**	_____-_____	_____	___Y ___N	_____
_____ **Intuniv/Tunix (Guanfacine)**	_____-_____	_____	___Y ___N	_____
_____ **Ritalin (Methylphenidate)**	_____-_____	_____	___Y ___N	_____
_____ **Strattera (Atomoxapine)**	_____-_____	_____	___Y ___N	_____
_____ **Catapres (Clonidine)**	_____-_____	_____	___Y ___N	_____
_____ **Ativan (Lorazepam)**	_____-_____	_____	___Y ___N	_____

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_____ **Buspar (Buspirone)**	_____-_____	_____	___Y ___N	_____
_____ **Valium (Diazepam)**	_____-_____	_____	___Y ___N	_____
_____ **Klonopin (Clonazepam)**	_____-_____	_____	___Y ___N	_____
_____ **Estrogen Hormone**	_____-_____	_____	___Y ___N	_____
_____ **Progesterone Hormone**	_____-_____	_____	___Y ___N	_____
_____ **Testosterone Hormone**	_____-_____	_____	___Y ___N	_____
_____ **Thyroid Hormone**	_____-_____	_____	___Y ___N	_____
_____ **Minipress (Prazocin)**	_____-_____	_____	___Y ___N	_____
_____ **Wellbutrin (Buproprion)**	_____-_____	_____	___Y ___N	_____
_____ **Zoloft (Sertraline)**	_____-_____	_____	___Y ___N	_____
_____ **Effexor (Venlafaxine)**	_____-_____	_____	___Y ___N	_____
_____ **Pristiq (Desvenlafaxine)**	_____-_____	_____	___Y ___N	_____
_____ **Remeron (Mirtazapine)**	_____-_____	_____	___Y ___N	_____
_____ **Serzone (Nefazodone)**	_____-_____	_____	___Y ___N	_____
_____ **Desyrel (Trazodone)**	_____-_____	_____	___Y ___N	_____
_____ **Elavil (Amytriptyline)**	_____-_____	_____	___Y ___N	_____
_____ **Norpramine (Nortriptyline)**	_____-_____	_____	___Y ___N	_____
_____ **EMSAM (Selegiline)**	_____-_____	_____	___Y ___N	_____
_____ **Marploan (isocarboxazid)**	_____-_____	_____	___Y ___N	_____
_____ **Nardil (Phenelzine)**	_____-_____	_____	___Y ___N	_____
_____ **Parnate (Tranylcypromine)**	_____-_____	_____	___Y ___N	_____
_____ **VNS**	_____-_____	_____	___Y ___N	_____
_____ **Light Box**	_____-_____	_____	___Y ___N	_____
_____ **Lithium**	_____-_____	_____	___Y ___N	_____
_____ **Depakote (Valproate)**	_____-_____	_____	___Y ___N	_____

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_____ **Keppra (Levetiracetam)**	_____-_____	_____	___Y ___N	_____
_____ **Lamictal (Lamotrigine)**	_____-_____	_____	___Y ___N	_____
_____ **Tegretol (Carbamazepine)**	_____-_____	_____	___Y ___N	_____
_____ **Trileptal (Oxcarbazepine)**	_____-_____	_____	___Y ___N	_____
_____ **Zonegran (Zonizamide)**	_____-_____	_____	___Y ___N	_____
_____ **Lyrica (Pregabalin)**	_____-_____	_____	___Y ___N	_____
_____ **Neurontin (Gabapentin)**	_____-_____	_____	___Y ___N	_____
_____ **Abilify (Aripiprazole)**	_____-_____	_____	___Y ___N	_____
_____ **Clozaril (Clozapine)**	_____-_____	_____	___Y ___N	_____
_____ **Fanapt (Iloperidone)**	_____-_____	_____	___Y ___N	_____

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TMS QUESTIONNAIRE

Check All That Apply:

	Depressed Mood		Agitation		Suicidal Ideations
	Loss of Motivation		Poor Energy		Poor Self Esteem
	Feelings of Worthlessness		Insufficient/Excessive Sleep		Increased Self Esteem
	Inappropriate Guilt		Decreased Need for Sleep		Being More Talkative than Usual
	Racing Thoughts		Weight Loss/Gain		Hyperexcitability
	Distractibility		Appetite Change		Foolish Investments
	Indecisiveness		Sexual Indiscretions		Shopping/Buying Sprees
	Poor Concentration		Suicidal Attempts		Grandiosity

Has your motivation and desire to accomplish more changed? How?

Has depression caused you to miss work or to be entirely unable to work? How? When? Which Job or Career?

Has depression caused you to perform at less than your best? How? When?

Do you still enjoy performing the same activities that you use to be involved in the past? (Name Activities)

Do you feel your relationships with your family and friends have been affected due to your depression? How?

Do you have days that you neglect your basic personal needs? Explain. (hygiene, skipping meals, unhealthy eating habits)

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