Transcranial Magnetic Stimulation (TMS) Screening

If you have any questions, please contact us by:
e-Mail: tms@moodtreatmentcenter.com Phone: (336)-276-1401

NAME (First, Last)	M.I.	BIRTH DATE	TODAY'S DATE
Who provides your psychiatric medications, or who referred you to TMS?			

Are you seeking TMS for: ☐ DEPRESSION ☐ OCD

Have you ever had…	**YES**	**NO**
Metal implants around the head		
Tattoos around the head		
Other implants in your body (e.g. vagal nerve stimulator, pacemaker, defibrillator)		
Seizures or epilepsy		
Stroke or problem with blood flow in the brain (e.g. cerebrovascular disease or transient ischemic attack)		
Dementia		
Repeated head trauma, head trauma with loss of consciousness, or any injuries to the brain		
Increased intracranial pressure in the brain (e.g. brain hematoma, brain edema, hydrocephalus, or brain conditions requiring a shunt)		
Brain tumors or cancer that spread to the brain		
Brain surgery		
Are you pregnant or nursing?		

Please list any existing medical conditions/ diagnoses that may affect your treatment (PTSD, diabetes, hypertensions, etc.)

Condition/Diagnosis	**Approximate Date of Diagnosis**

Current Medications

NAME	DOSE	WHEN DID YOU START IT?

Past Psychiatric Medications

Have you ever been admitted to a hospital for mental health? ☐ YES ☐ NO ☐ YES to ER but not admitted

Please list all psychiatric medications you've tried. Look over the next page for examples. If you have received psychiatric care outside of our practice, please complete the Release of Information at the end of this packet.

		How did you respond?				
Medication	Approximate start & stop dates or Year & duration	Felt better on it	No difference / unsure	Felt worse on it	Worked at first, wore off	Notes/Side Effects

Examples of Psychiatric Meds

Antidepressants

SSRIs (fluoxetine/prozac, sertraline/zoloft, paroxetine/paxil, fluvoxamine/luvox, citalopram/celexa, escitalopram/ lexapro)

Vortioxetine/trintellix, vilazodone/viibryd

SNRIs (venlafaxine/effexor, duloxetine/cymbalta, desvenlafaxine/pristiq, milnacipran/savella, levomilnacipran/fetzima)

Wellbutrin (buproprion, budeprion, aplenzin)

Remeron/mirtazipine

Serzone, nefazodone, trazodone, desyrel, oleptrol

Tricyclics (imipramine, clomipramine, amitriptyline, nortriptyline, doxepin, protriptyline, elavil)

MAOIs (selegiline/emsam, phenelzine/nardil, tranylcypromine/parnate, isocarboxazid/marplan)

Naturals: St John's Wort, Deplin, SAMe, Omega3, Fish oil, NAC, Chromium, Deplin, Lightbox, Vitamin B, Folate/folic acid, Kava Kava

Mood Stabilizers

Lamotrigine, lamictal

Lithium, lithobid, eskalith

Depakote, valproate

Oxcarbazepine, trileptal

Carbamazepine, tegretol, equetro

Antipsychotics / Mood Stabilizers

Atypicals (aripiprazole/abilify, quetiapine/seroquel, lurasidone/latuda, olanzapine/zyprexa, symbyax, brexpiprazole/rexulti, cariprazine/vraylar, asenapine/saphris, paliperidone/invega, risperdal/risperidone, ziprasidone/geodon, iloperidone/fanapt)

Typicals (haldol, haloperidol, thorazine, chlorpromazine, stelazine, prolixin)

Clozaril, clozapine

Antianxiety

Benzodiazepines (ativan, lorazepam, klonopin, clonazepam, xanax, alprazolam, oxazepam, restoril, temazepam, etc.)

Buspar, buspirone

Neurontin, gabapentin

Pregabalin, lyrica

Stimulants and ADHD Treatments

Stimulants (ritalin, methylphenidate, metadate, methylin, concerta, adderall, dexedrine, zenzedi, vyvanse, focalin, quillivant)

Guanfacine, intuniv, clonidine, kapvay

Strattera, atomoxetine

Provigil, modafinil, nuvigil, vayarin, vayacog

Other

Anticonvulsant (lyrica, pregabalin, gabatril, tiagabine, neurontin, gabapentin, keppra, levetiracetam, topamax, topiramate)

Provigil, modafinil, nuvigil

Synthroid, levothyroxine, cytomel, T3, T4

Mirapex, pramipexole, requip, ropinorole, neupro

Counseling & Therapy

Have you tried therapy for your current symptoms? ☐ YES ☐ NO

Are you currently in therapy? ☐ YES ☐ NO Therapists' name _____

If you answered **YES** above, please indicate the frequency you attend therapy: _____

Have you tried other programs to treat your current symptoms?

☐ EXERCISE ☐ MEDITERANIAN DIET ☐ YOGA ☐ MINDFULNESS ☐ LIGHT THERAPY

Other _____

List any counseling or therapy you've had in the past:

		Frequency of Visits	Did it help alleviate symptoms?			
Therapists' name	Start & stop dates or Year & duration		Yes, fully	Part of the way	No	Did it involve "homework" or exercises to do out of session?

Past TMS

Have you tried TMS in the past? ☐ YES ☐ NO

Which device? ☐ NEUROSTAR ☐ BRAINSWAY/DEEP ☐ OTHER

			Did it help alleviate your symptoms?				
Place of TMS	Year	Number of sessions	Yes, fully	Part of the way	No	Worked at first, wore off	Side effects or problems with TMS

ECT

Electroconvulsive therapy (ECT) treats depression by creating electrical seizures in the brain.

			Did it help alleviate your symptoms?				
Place of ECT	Year	Number of sessions	Yes, fully	Part of the way	No	Worked at first, wore off	Side effects or problems with ECT

Would you consider ECT for your current depression? ☐ YES ☐ NO ☐ MAYBE

Intensive OCD Treatment Programs (In/Out Patient)

Have you tried an intensive treatment program in the past? ☐ YES ☐ NO

			Did it help alleviate your symptoms?				
Place of Treatment	Year	Duration	Yes, fully	Part of the way	No	Worked at first, wore off	Side effects or problems with Treatment

Agreement to Treatment

1) *I will show up 15 minutes early for my TMS appointments.* Our TMS spots are limited. If you arrive late for any reason you may need to skip that treatment day. We may need to cancel treatment if you arrive late or miss session more than 3 times.
2) *Payment:* I agree to pay for any services not covered by my insurer as well as any copays or deductibles that are due. I understand that the Mood Treatment Center will provide an estimate of that cost and that that estimate is not a guarantee of insurance coverage.
3) *Deposit:* I will make a deposit equal to 2 weeks of treatment out of my estimated costs before beginning TMS and pay the remaining 50% half-way through the treatment. If I do not complete the treatment any unused funds will be returned to me.
4) *Confidentiality:* I authorize the Mood Treatment Center to release information about my medical history to my insurer in order to authorize TMS.

In signing below, you agree to begin treatment with the policies above.

Signature of Patient	Date	Signature of Parent/Guardian (if under 18)	Date

Questions You'd Like Addressed

Write down any questions you'd like us to address so they're not forgotten:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the PAST WEEK, how long have you been bothered by any of the following problems (circle number):	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 could 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
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**				

10. If you checked off *any* problems, how *difficult* have these 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 _____	0
	Somewhat difficult _____	1
	Very difficult _____	2
	Extremely difficult _____	3

Complete the next rating scale if you need TMS for Obsessive Compulsive Disorder (OCD)

APPENDIX A

The Florida Obsessive Compulsive Inventory

General Instructions: The questions below are designed to help health professionals evaluate anxiety symptoms. Keep in mind, a high score on this questionnaire does not necessarily mean you have an anxiety disorder — only an evaluation by a health professional can make this determination. Answer these questions as accurately as you can.

Part A instructions
Please circle YES or NO for the following questions, based on your experience in the past MONTH:

Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind, such as:			
1	Concerns with contamination (dirt, germs, chemicals, radiation) or acquiring a serious illness such as AIDS?	YES	NO
2	Overconcern with keeping objects (clothing, tools, etc) in perfect order or arranged exactly?	YES	NO
3	Images of death or other horrible events?	YES	NO
4	Personally unacceptable religious or sexual thoughts?	YES	NO
Have you worried a lot about terrible things happening, such as:			
5	Fire, burglary or flooding of the house?	YES	NO
6	Accidentally hitting a pedestrian with your car or letting it roll down a hill?	YES	NO
7	Spreading an illness (giving someone AIDS)?	YES	NO
8	Losing something valuable?	YES	NO
9	Harm coming to a loved one because you weren't careful enough?	YES	NO
Have you worried about acting on an unwanted and senseless urge or impulse, such as:			
10	Physically harming a loved one, pushing a stranger in front of a bus, steering your car into oncoming traffic; inappropriate sexual contact; or poisoning dinner guests?	YES	NO
Have you felt driven to perform certain acts over and over again, such as:			
11	Excessive or ritualized washing, cleaning or grooming?	YES	NO
12	Checking light switches, water faucets, the stove, door locks or the emergency brake?	YES	NO
13	Counting, arranging; evening-up behaviors (making sure socks are at same height)?	YES	NO
14	Collecting useless objects or inspecting the garbage before it is thrown out?	YES	NO
15	Repeating routine actions (in/out of chair, going through doorway, relighting cigarette) a certain number of times or until it feels **just right**?	YES	NO
16	Needing to touch objects or people?	YES	NO
17	Unnecessary rereading or rewriting; reopening envelopes before they are mailed?	YES	NO
18	Examining your body for signs of illness?	YES	NO
19	Avoiding colors ("red" means blood), numbers ("13" is unlucky) or names (those that start with "D" signify death) that are associated with dreaded events or unpleasant thoughts?	YES	NO
20	Needing to "confess" or repeatedly asking for reassurance that you said or did something correctly?	YES	NO

If you answered YES to one or more of these questions, please continue with Part B.

APPENDIX A

The Florida Obsessive Compulsive Inventory (continued)

Part B instructions The following questions refer to the repeated thoughts, images, urges or behaviors identified in Part A. Consider your experience during the past 30 days when selecting an answer.
Circle the most appropriate number from 0 to 4.

In the past month...					
1. On average, how much *time* is occupied by these thoughts or behaviors each day?	0 None	1 Mild (less than 1 hour)	2 Moderate (1 to 3 hours)	3 Severe (3 to 8 hours)	4 Extreme (more than 8 hours)
2. How much *distress* do they cause you?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme (disabling)
3. How hard is it for you to *control* them?	0 Complete control	1 Much control	2 Moderate control	3 Little control	4 No control
4. How much do they cause you to *avoid* doing anything, going anyplace or being with anyone?	0 No avoidance 0	1 Occasional avoidance	2 Moderate avoidance	3 Frequent and extensive avoidance	4 Extreme avoidance (house-bound)
5. How much do they *interfere* with school, work or your social or family life?	0 None	1 Slight interference	2 Definitely interferes with functioning	3 Much interference	4 Extreme interference (disabling)

For clinician use:
Sum on Part B

(Add Items 1 to 5): _____

Keep in mind, a high score on this questionnaire does not necessarily mean you have an anxiety disorder -— only an evaluation by a health professional can make this determination.

Authorization for use and disclosure of protected information

What's this for?

To ask your mental health provider to send records to the Mood Treatment Center for TMS authorization.

❶ Patient information

Name: _____ DOB: _____ Phone: _____

Address: _____

❷ Who you need to send records

I (the above named patient) request that the health care provider below:

Person, provider or facility: _____

City: _____ State: _____

Release the following information (check as many as might apply):

___ Psychiatric Records
___ Substance Abuse Treatment
___ Psychological Testing
___ Records of Psychiatric Hospitalization
___ Medical Records
___ Diagnostic & Laboratory Testing
___ Conversation
___ Other _____

Regarding services rendered during the following dates: _____

To: Mood Treatment Center TMS Dept, 104 Cambridge Plaza Dr, Winston-Salem, NC 27104-3556
Fax: (336) 201-0538 Phone: (336) 722-7266 Email: tms@moodtreatmentcenter.com

The purpose of this disclosure is treatment and coordination of care.

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the health care provider named above. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that this authorization for disclosure is voluntary and that I need not sign this form to ensure healthcare treatment.

❸ Signature and expiration

This authorization will expire on _____ (if blank it expires 12 months from the date signed)

Signature of patient: _____ Date_____

Signature of parent/guardian if under 18: _____ Date _____

Do you have other past providers with psychiatric records? Print more forms at:
www.moodtreatmentcenter.com/releasetotms.pdf

Authorization for use and disclosure of protected information

What's this for?
To allow the Mood Treatment Center to communicate with others about your treatment.

❶ Patient information

Name: _____ DOB: _____

❷ Who you're allowing communication with, and what you want released

I (the above named patient) request the Mood Treatment Center communicate with:

Person, provider or facility: _____

City: _____ State: _____

To release the following information:

___ Psychiatric Records
___ Substance Abuse Treatment
___ Psychological Testing
___ Records of Psychiatric Hospitalization
___ Medical Records
___ Diagnostic & Laboratory Testing
___ Conversation
___ Other _____

Regarding services rendered during the following dates: _____

The purpose of this disclosure is:

___ Treatment ___ Legal ___ Disability ___ Family involvement

Other: _____

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the Mood Treatment Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. Also, the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.

I understand that this authorization for disclosure is voluntary and that I need not sign this form to ensure healthcare treatment.

❸ Signature and expiration (choose an expiration date far in the future if you don't want it to expire)

This authorization will expire on _____ (if blank it expires 12 months from the date signed)

Signature of patient: _____ Date_____

Signature of parent/guardian if under 18: _____ Date _____

Do you have other people you'd like us to coordinate with? Print more forms at:
www.moodtreatmentcenter.com/releasefromtms.pdf

PHONE (336) 722-7266 www.moodtreatmentcenter.com (336) 201-0538 FAX
104 Cambridge Plaza Dr, Winston-Salem, NC 27104 tms@moodtreatmentcenter.com