TMS INTAKE FORM

Today's Date: ____________________________

Last Name: ________________________________ First Name: _______________________________

Address: ____

Home Pone: ______________________________ Cell Phone: _________________________________

Work Phone: ______________________________ Email Address: _______________________________

Preferred Contact Method from Above: ____

SSN: _____________________________________ DOB: ___(/ /)_ __________

Sex: _____________________________________

Marital Status: **Single** **Married** **Separated** **Divorced** **Widow/er**

Primary Care Physician: ____

PCP Phone: _______________________________ PCP Fax: ___________________________________

Employment Status (Select One):

Employed FT	
Employed PT	
Unemployed	
Retired	
Homemaker	
Student	

Current Employer / Address: ____

Consent for Treatment:

The following information is to be completed by the patient or the patient's legally authorized representative/parent:

I consent to medical treatments for myself or for the patient for whom I am the parent or legally authorized representative. I understand that Upstate Psychiatry will share patient health information according to state and federal law for treatment, payment, and operations.

I understand that I am responsible for all charges incurred, regardless of the patient's insurance status. I agree to pay for services as the patient incurs the charges. I authorize the insurance provider to pay Upstate Psychiatry for services rendered.

I agree that it may take up to 3 visits before I am accepted as a patient at Upstate Psychiatry.

Signature of Patient: ____ Date: ______________________

Signature of Legally Authorized Representative: ________________________________ Date: __________________

Relationship of Legally Authorized Representative to Patient: ____

Please Complete All Items for Proper Review. Please DO NOT Leave Any Items Blank:

Current Age: _____________________________

Primary Insurance Carrier Name: _____________________________________

Member ID:____

Primary Insured Name:____

Primary Insured DOB: ____

Secondary Insurance Carrier Name: __________________________________

Current Psychiatrist Name and Address: ____

Previous Psychiatrist Name and Address: ____

Reason for Leaving the Above Psychiatrist: ____

Current Therapist Name and Address: ____

Are you currently suicidal? ___________________________ Are you currently Homicidal?__________________

What is your current diagnosis? ____

Which controlled substance are you currently on? (Medicinal cannabis, Percocet, Oxycodone, Hydrocodone,

Morphine, Xanax, Klonopin, Adderall, Valium, Ritalin, Ativan, etc.) ____

____

Which controlled substance do you expect to be prescribed? ____

How much alcohol do you drink? ____

Which recreational drug (s) do you currently use? ____

Do you have a legal case pending? If so, briefly describe this: ____

____

____

Are you currently on disability? _______________________

Do you need disability paperwork completed? ____________________________

Emergency Contact(s):	
Name: ______________________________________	Name: ______________________________________
Relationship to Patient: _________________________	Relationship to Patient: _________________________
Home Phone: _________________________________	Home Phone: _________________________________
Cell Phone: ___________________________________	Cell Phone: ___________________________________
Work Phone: __________________________________	Work Phone: __________________________________
Address: _____________________________________	Address: _____________________________________

NeuroStar TMS Therapy Intake Questionnaire

Have you heard about Transcranial Magnetic Stimulation? (Yes or No) ____________________________________

Are you interested in this non-drug treatment for depression/anxiety? ____________________________________

Can you tell us how long you have suffered from depression/anxiety? _____________________________________

____

____

Record length and episodes? ____

____

What treatments have worked to provide remission of your depression/anxiety in the past? _____________________

____

Are you in therapy right now? Yes or No? ____

If yes, please provide your therapist's name: ____

Do you have any medical conditions including but not limited to: diabetes, seizures, strokes, etc.? _______________

____

Do you have any metallic objects implanted in or around your head? ______________________________________

What current medications are you taking? ____

____

What side-effects have you had from them? ____

____

List ALL psychiatric medications you have tried in the past (please circle on the list on the next page in addition to listing):
____

Current or Previous medications tried (please circle)

Atypical antidepressants:

bupropion (Wellbutrin)	nefazodone (Serzone),	vilazodone (Viibryd)
mirtazapine (Remeron)	trazodone (Desyrel) (Oleptro)	vortioxetine (Brintellix)

Antipsychotics:

geodon (ziprasidone)	seroquel (quetiapine)	vralar
abilify (aripiprazole)	olanzapine (zypreza)	risperidone (risperdal)

Selective serotonin Reuptake inhibitors (SSRIs) include:

citalopram (celexa)	fluoxetine (Prozac)	fluvoxamine CR (Luvox CR)	paroxetine CR (Paxil CR)
escitalopram (Lexapro)	fluvoxamine (Luvox)	paroxetine (Paxi|)	sertraline (Zoloft)

Serotonin-Norepinephrine Reuptake inhibitors (SNRIs):

desvenlafaxine (Pristiq)	venlafaxine (Effexor)	milnacipran (Savella)
duloxetine (Cymbalta)	venlafaxine XR (Effexor XR)	evomilnacipran (Fetzima)

Tricyclic antidepressants:

amitriptyline (Elavil)	desipramine (Norpramin)	doxepine (Sinequan)	Imipramine (Tofranil)	nortriptyline (Pamelor)
amoxapine	clomipramine (Anafranil)	maprotiline (Ludiomil)	trimipramine (Surmontil)	protriptyline (Viivactil)

Monoamine oxidase inhibitors (MAOIs):

phenelzine (Nardil)	selegiline (Emsam)	tranylcypromine (Parnate)

Mood Stabilizer:

Lithium	Depakote (Valproate)	Neurontin (gabapentine)
Carbamazepine	Topamax (Topiramate)	Synthroid

Others:

How has depression and anxiety affected you in terms of:

Relationships: ____

____.

Work: ____

____.

Socialization: ____

____.

Hobbies: ____

____.

Education: ____

____.

If you have any further questions/concerns or information you would like us to consider during your intake's review, please include it below:

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____

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Thank you again for your interest in Upstate Psychiatry's Medication Management, Therapy, and/or TMS Services. Please allow up to 6 weeks from the day we receive your completed paperwork to finish its review.

Please mail completed forms to:

3070 Belgium road

Baldwinsville, NY 13021

Or email UpstatePsychiatryTMS@yahoo.com