Depression Clinic at the health centers
2621 Raymond Drive * St Charles, Missouri 63301
T 636.946.2244 F 636-946-6975

TMS - NEW PATIENT INFORMATION PACKET

Please READ all of this page before you begin…

Thank you for your interest in becoming a new patient at our *Depression Clinic at the health centers*. Our patients say *our office staff treat them like family* & *our deep TMS (dTMS) therapy is the best of the best* because we pay attention to every detail & our patients see great results. We just say *thank you* because we feel *you deserve the best*!

Our website will answer a lot of your questions, but our trained staff are always here to help you. We understand depression, anxiety and how mental health conditions & medications interfere with your life which is why all of us are committed to help you '*recover & return to a normal life'*

This New Patient Information packet contains -7- pages. Some of the type size is small so if you need assistance reading the small print or understanding how to answer the questions or completing these forms please let us know. There are a lot of questions & it may take you 60 minutes to complete but we hope it demonstrates our commitment to you & our attention to details. Please type or PRINT all responses in black ink and answer each question as completely as possible. Use a separate paper to type or PRINT as much info as you feel is beneficial for us to know.

If you currently see a psychiatrist, mental healthcare provider or are a Veteran through a VA health center or VA hospital or if your regular primary care provider recommended TMS please ask them to fax us an order for you stating:

"Deep TMS therapy at the Depression Clinic at the health centers for MDD and/or (diagnosis)"

You may need to emphasize to your referring provider that you desire to get your deep TMS therapy at our clinic so we can ensure you get the best care.

When you have completed all 7 pages of this New Patient packet call our office & schedule an appointment for your *TMS Screening Evaluation*. Bring these 7 pages, your driver's license & all health insurance cards with you. We start with this screening evaluation to determine if you *safely* qualify for dTMS with one of our medical staff performing a medical exam, skull x-ray and a urine drug test. After the medical staff approves you for dTMS, our psychiatrist will consult with you in person or speak with you on a tele-health call and will order your dTMS treatment. There is a $150 fee for the evaluation, x-ray & urine drug test that we ask you to pay on this visit.

We accept nearly every insurance plan so our billing staff will call your insurance company & get your entire dTMS treatment program pre-authorized which usually only takes a few days. If you do not have insurance coverage our staff will assist you qualify for an EZ payment plan through CareCredit. Once your insurance company or CareCredit authorizes your treatment, we will call & schedule your first TMS treatment. This visit takes about 60 minutes because we go above & beyond the 'norm' and do things for your safety that other TMS centers generally do not do. During this visit our TMS staff will perform a painless brain mapping to determine the best placement for the magnetic stimulation and administer your first dTMS treatment.

Our dTMS treatment is painless. During your 30 minute treatment our Brainsway dTMS machine precisely administers a magnetic wave stimulation to an exact location in your brain through a therapeutic helmet on your head. All of *our certified, trained staff* strive to give *service beyond belief* and treat each of our patients with respect, dignity and encouragement. We are very detailed and *our primary focus is on helping you restore normal mental health,* free of depression & anxiety without being dependent on medications.

Our staff will schedule your treatments daily for 8 weeks. Our staff are very professional and will be in the room with you the entire time you are receiving TMS and your family is welcome to be in the room during treatment, but using your cell phone is not allowed.

We want you to maintain a normal sleep schedule and eat, drink & exercise as you normally do during your 8 weeks of treatment. We strongly recommend you do not use alcohol or social drugs during the treatment program. You must take all medications your doctors prescribe but be sure to tell us about any change in drugs, vitamins & supplements, diet, lifestyle, sleep or anything that effects your mental state before each treatment.

Service beyond belief means a lot to us and we will work hard to *exceed your expectations.* Please share our website with your family & friends who we may help & call our staff anytime at 636-946-PAIN.

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NEW PATIENT INFORMATION

Name _____ Age _____ Sex _____ Today's Date _____

Street Address _____ City / State _____ Zip _____

Social Security _____ Birthdate _____ E Mail Address _____

Cell Phone _____ Employer _____ Occupation _____

☐ Married ☐ Single ☐ Sep ☐ Divorced ☐ Widowed Spouse's Name _____

Your Drs Name _____ Drs Phone No _____

Pharmacy Name _____ Pharmacy No _____

How Did You Hear About Our Office _____

Why Are You Seeing Our Provider Today _____

HEALTH INSURANCE INFORMATION

Name of Insurance Company _____ Group Number _____

Name of Insured (Policy Holder) _____ Policy Number _____

MENTAL HEALTH CARE PROVIDER INFORMATION

Name of Mental Healthcare Provider _____

Name of Mental Healthcare Hospital _____ Phone Number _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Person(s) _____

Relationship _____ Phone Number _____

PROVIDE RECEPTIONIST WITH COPY OF DRIVER'S LICENSE & INSURANCE CARD

Welcome to our mental health & behavioral health practice. The Depression Clinic at the health centers, llc is an independent practice and limited liability company. Our practice is independent but works closely with The Health Centers, PC which is a multi-specialty group practice offering adult family practice, internal medicine, orthopedics & pain management medical care, chiropractic, physical therapy, rehabilitation, acupuncture, massage therapy, nutritional & many other services. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are discouraged from using cell phones while in our office due to federal privacy rules and possible effects from the TMS magnetic coil. Unauthorized photography of our patients is prohibited. Patients are strongly encouraged to leave valuables at home or with an accompanying family member or friend because this facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items. This facility, its doctors & staff are accepting your case based on examination and/or evaluation findings & believe the recommended treatment should produce change and/or improvement. However, as with any diagnostic test, procedure, examination or doctor's care, a guarantee of improvement or complete recovery cannot be made, and it is even possible that no change will occur. Please understand that in the practice of medicine, surgery, chiropractic, podiatry, psychiatry, counseling, massage, physical, occupational , speech & respiratory therapy there are some risks including but not limited to headaches, muscle cramps & spasms, blurred vision, dizziness, vertigo, ringing in your ears, nausea, heart-attack, drug interactions, procedural complications, reactions, seizures, cardio-pulmonary arrest, death and/or other incidents which may be short or long term or side effects & cannot be pre-determined. By your signature you acknowledge that you do not expect any of our doctors, therapists or providers to be able to anticipate & explain all risks and/or complications, and you wish to rely on the doctor, therapist and/or provider to exercise judgment during the course of the procedure(s) which the doctor/therapist/provider feels at the time is in your best interest. In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Patients have the right to refuse treatment, but if you refuse and/or fail to comply with prescribed treatment our facility, providers & staff are not responsible for any consequences. Therefore, you grant your full consent to all staff at this facility including but not limited to a doctor, nurse practitioner, therapist, nurse, chiropractor, healthcare provider or staff member to perform any examinations, diagnostic tests &/or treatment as may be considered medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties which we deem on your behalf. Our office and staff are committed to providing all patients quality health care services delivered with dignity and concern regardless of race, color, national origin, age, sex, disability or religious or political beliefs. HIPAA requires that we make you aware of the federally governed Health Care Privacy Notice, which is provided to you and explains when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff. Your initials below and signature on the backside of this document confirm that you have read or had read to you understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all of our office policies, consents, terms & conditions regarding your responsibilities to pay all money owed in ninety days or less from the date the service was rendered or you will be fully responsible for all collection costs including but not limited to money owed, late-fees, interest, collection costs, attorney and court fees. By your initials & signature you are also confirming that you grant the physicians, doctors, chiropractors, nurse practitioners, therapists and/or all staff of this facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of any money you may owe this facility and/or for issues that concern this facility operations and responsibilities. We encourage questions to avoid misunderstandings, so please direct any questions or concerns to a member of our staff. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment, please notify us at least 24 hours in advance because if you do not show up for your scheduled appointment you will be charged $50 as a missed appointment fee that you must pay before you are seen or treated again. As a courtesy to you, we may call you, text you or e-mail you for an appointment reminder or when an appointment is missed. If you do not wish for us to call you or contact you, please let us know in writing for your file. Please acknowledge you have read & understand this document by signing your initials in the square in on the bottom right corner on all forms & fill in or sign at every "☺".

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HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

We understand that healthcare information about you and your health is personal. This facility is required by law to abide by the terms of HIPAA, the Health Care Privacy Notice, the Security Rule, as well as other applicable federal and state laws governing privacy practices in health care so the doctors, therapists & staff at this office are committed to protecting your medical information but the federal government, under HIPAA, the Privacy Notice, the Security Rule and our own office administration requires us to make sure you are aware and be sure you understand, agree to adhere with and have read or have had read to you all of the following policies & procedures. In addition, this office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patients working together as a team to obtain the maximum results because your satisfaction is a vital interest to us. Our facility may change and/or modify the terms of this Notice and/or any of our policies at any time without additional notice to you except to publicly post in our facility and/or make available to patients updated notices. Photocopy of this Notice is available to you upon request. The term facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility. Our facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI includes but is not limited to your medical records and personal information such as your name, social security number, address, birth date, phone number and includes demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice or records from another facility that have been forwarded to our office and are now a part of your medical record. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this facility. Our facility may use & disclose your PHI with or without your written authorization to anyone at any time for any reason including but not limited to health care delivery purposes, your care, treatment(s), collecting money due this facility, to support any operation of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. All requests must be in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee or a processing fee for their time which will be in compliance with state law. You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed, and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. Privacy Law prohibits our facility from taking any retaliatory actions against anyone who files a complaint. I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed, hereinafter referred to as the "facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of an accident, injury, illness or health condition for which I have been treated by the facility. I further irrevocably agree to pay all money and/or charges owed this facility in full within 90 days of the date of occurrence, service or treatment, even if an insurance claim submitted on my behalf is delayed or denied for any reason and/or a case manager or attorney representing me for any accident, injury or illness has not settled my case. I, the assignee further authorizes and instructs any and all insurance company(ies), attorney and any & all third party payers to pay directly to the facility in full all sums of money due them for any & all services rendered to me or minor by whom I am fully responsible to pay in full all money owed to this facility for all reason including but not limited to any accident, injury, illness or health condition and any other bills that are due or may become due, and to withhold such sums from any payments or settlements from including but not limited to health insurance, third party payment and/or benefit, accident, workers compensation payments or settlements. Also, by my signature and as the assignee I irrevocably agree that this facility & staff may process medical reports, deliver medical records, render consultations, depositions and/or court appearances, all of which must be paid in full in advance by me if not paid in advance by my attorney or representative. I further authorize this facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this facility & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, our office (facility) will attempt to obtain a verification of your applicable insurance benefits and will report them to you or assume they are accurate as they are quoted to us but some third party payers, case managers and/or attorneys misquote benefits, coverage and liability so our facility & staff are not responsible for what someone may tell us. Any and all contractual, written, verbal or other obligations or arrangements between you and an attorney, case manager, insurance company, liable or third-party payer are between you and said person or company and do not delay or offset your obligation to pay.

1. Our facility will file applicable insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due in advance of or on the day the service is rendered.
3. Patients are fully responsible to pay all charges for service(s) &/or product(s) which may be denied or not covered for any reason by an insurance carrier, case manager, attorney &/or when a third party &/or insurance carrier does not reimburse enough to meet our cost of service. Money pre-paid is non-refundable.
4. All account balances, including accident and injury claims which are represented by an attorney must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third-party payer fails to pay this facility the said balance in full within the 90-day period, the patient must pay the balance in full. The assignee is fully responsible for all money owed this facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. When there is no insurance to cover services, a non-discriminatory "Time of Service Discount" (TOS) is offered to anyone who pre-pays or pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered and does not apply to the following items & services including but not limited to durable medical equipment, orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, medications, supplements, psychological, mental and/or behavioral health services, massage therapy, med spa services and other services.
6. A service charge is computed by a 'periodic rate' of 1½ % per month – 18% per annum & is added to all balances owed 90+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to pay and be 100% responsible for all money owed this facility for services plus all money owed including but not limited to monthly service charges, late fees, collection related expenses, attorney fees, court & filing fees. Returned checks, debit & credit charges made payable to this facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $50.00 charge. Patients are eligible for a max $250 personal credit limit when approved by our insurance manager & we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge I have read or have had read to me and understand and agree to be irrevocably responsible for all terms & conditions. I also acknowledge that I have received a photocopy of the Privacy Notice and upon my request of this document and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as original.

☺ _____

Print Name of Patient or Legal Guardian

☺ _____ _____

Signature (if minor, parent must sign) Date

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TMS INFORMATION * AUTHORIZATION & CONSENT FORM

PATIENT	BIRTHDATE	PSYCHIATRIST	TODAYS DATE
DIAGNOSIS OR TREATING CONDITION		OFF-LABEL CONDITION	

INFORMATION

Transcranial Magnetic Stimulation (TMS) is an FDA approved therapy that has been used since 1985 for treatment-resistant major depressive disorders (MDD). Several other mental health conditions favorably respond to TMS and are referred to as off-label treatments. Anxiety, addictions, obsessive-compulsive disorders, learning, behavioral, memory & post-traumatic stress disorders have all shown clinical efficacy with TMS treatment. TMS therapy is non-invasive, medical procedure performed by a psychiatrist and/or trained technicians. The *Depression Clinic at The Health Centers* uses a specific type of TMS referred to as 'Deep TMS' & our office is very careful which is why prior to beginning dTMS therapy every new patient will be evaluated by one of our medical staff to make sure you are qualified to receive dTMS. Each dTMS treatment takes approximately 20 minutes while you are fully awake and sitting in a comfortable room with your family or friend. The TMS machine targets and stimulates pulsed magnetic fields similar in type and strength as those used in an MRI to neurons in the prefrontal cortex region of the brain through a coil in a cushioned helmet coil which is comfortably resting on the patient's head. During treatment, patients will hear a clicking sound so earplugs are available to reduce noise and may also feel a tapping sensation on their scalp. During the initial evaluation a brain-mapping procedure will be done to map the brain and program the TMS machine so electromagnetic pulses are administered into the brain. During the brain mapping patients will notice their right-hand twitch which is called the motor threshold. Once the threshold is reached the TMS machine will be set to administer a series of 'pulses' that last about 2 seconds with a resting period of 20 seconds between them for approximately 20 minutes. A course of TMS treatment for depression typically consists of 36-44 treatments, scheduled daily, 3 times a week or as often as the psychiatrist feels is needed for 8 weeks. For our patients' convenience we offer early & late appointments M-F & Sat because you keeping your regular appointments is important for your improvement.

CONFIDENTIALITY & SAFETY

Our staff will protect patient confidentiality whenever possible, and we have a private entrance to accommodate privacy upon request. The safety of TMS therapy has been widely demonstrated to be very safe with minimal adverse effects but like other medical procedures and treatments TMS may involve some low risks including but not limited to headaches, dry mouth, site discomfort, muscle twitching, insomnia, ringing of the ears, biting the tongue or seizures. TMS should not be used if a patient has any metal in the skull or neck, chest or upper back including cardiac implanted devices, metal surgical staples, tattoos or permanent make-up. The effectiveness of TMS therapy has been studied but long-term effects of TMS are still unknown.

ALTERNATIVE TREATMENT OPTIONS

Psychiatrists and doctors recommended TMS therapy because it works so well but a variety of other treatment options may exist and the appropriateness depends on a variety of factors including but not limited to previous experiences, severity of my disorder, potential risks and/or side effects. Treatment options may include psychotherapy, medication, IV infusion therapy and electro-convulsive therapy (ECT).

INSURANCE & COST OF CARE

Most health insurance carriers cover all or part of TMS treatment costs. The *Depression Clinic at the health centers* make every attempt to obtain Pre-Authorization for TMS therapy treatment with your insurance carrier(s); however, Pre-Authorizations does not always guarantee coverage or payment. Patients are 100% responsible for all payments, co-pays, deductibles, and any services not paid by a third party. If an insurance company issues a Pre-Authorization for your treatment of the *Depression Clinic at the health centers,* we will wait 30 days after each claim is submitted for payment but all unpaid claims 30+ days are due in full by the patient. Our facility requires payment from patient or a healthcare finance company at the time of service or in advance from patients for all non-covered services and patients without insurance coverage. Patients who miss an appointment and do not notify us at least 24 hours in advance of the cancellation are personally responsible to pay $50.00 as a cancellation fee. Patient payments may be made by cash, check, credit/debit card, pre-approved payment plan or one of the pre-approved healthcare financing companies.

AUTHORIZATION

By my signature below I attest that I am the patient and/or legal guardian of the patient and fully agree that I have read or have read to me, understand and have had all of my questions answered regarding TMS - Transcranial Magnetic Stimulation and give my full consent to receive Deep TMS therapy and other diagnostic tests and/or treatments for my mental health condition at this facility. I understand that a positive outcome cannot be guaranteed and that TMS is not effective for all patients with depression, other mental health issues or off-label conditions and that my symptoms may even worsen. I understand that positive outcomes are dependent on my compliance to treatments, and I commit to attend all treatments as scheduled, knowing that if I miss 2 or more treatments, I may be released from my treatment program and be responsible for costs. I acknowledge that I am welcome to ask any questions and that I may discontinue treatment at any time. I fully understand that it is my responsibility to correctly report my past and present health history to the staff at this facility prior and/or during any treatment, including but not limited to medications, illnesses, diseases, surgeries, therapies and to report any familial history, social and occupational risks and I promise to also report any feelings or side effects, symptoms and/or changes in my life during or after any TMS session and not use any social or non-prescribed drugs during the TMS treatment program. I attest that I have had all of my questions answered regarding treatment options and potential risks as presented to me by this facility. I therefore fully and totally release and hold harmless the Depression Clinic at the health centers llc, The Health Centers, PC, owners, affiliates, each of its employees, physicians, associates and staff of either facility or company from of all liability resulting from anything that may occur which is not known or a normal occurrence. I hereby give my full permission to this facility, doctor(s) and staff to administer any and all treatment(s) to me that may seem applicable or for my benefit or the benefit of the patient for whom I am legal guardian.

PRINT NAME ☺_____ SIGNATURE ☺_____ DATE SIGNED ☺____/____/____

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MENTAL HEALTH QUESTIONAIRE

PATIENT	BIRTHDATE	REFERRAL SOURCE	TODAYS DATE

1. Are you now or in the past been treated by a therapist, psychologist, or psychiatrist for individual or group mental health therapy NO YES
2. Are you now or in the past been diagnosed with any form of depression, anxiety &/or a mental or neurological health condition NO YES
3. Are you now or in the past taken any prescription medication for depression, ever had any seizures or any mental health issues NO YES
4. Are you now or in the past ever taken non-prescription drugs or tried treatments not prescribed by a licensed doctor or therapist NO YES
5. Are you now or in the past been treated as an in or out-patient for addiction, depression, suicide, seizure or psychiatric illness NO YES
6. Are you now or in the past been treated with any electro-convulsive therapy (ECT) or transcranial magnetic stimulation (TMS) NO YES
7. Are you now or in the past been told that you have any metal in your head or neck from an injury, surgery or any other reason NO YES
8. Are you now or in the past been arrested, jailed, or charged, lost a job or been disabled due to alcohol or drug related offense NO YES
9. Are you now or in the past been treated for or had suicidal thoughts or wanted to hurt yourself or someone else by any means NO YES
10. Are you pregnant, trying to get pregnant, nursing, recovering from surgery, have metal in your body or Vagal Nerve Stimulator NO YES
11. Are you now or in the past used any marijuana, opiates, cocaine, hallucinogens, benzodiazepines, Klonopin, Xanax, Activan NO YES
12. Are you being referred to our office by a psychiatrist, psychologist, therapist, doctor or court of law for a specific type treatment NO YES
13. Have you ever had TMS before (if yes - please explain)_____ NO YES
14. How old were you when you were first treated for mental illness _____ years old & what year was this _____
15. Name of your current family MD or nurse practitioner _____ Last time you saw them _____
16. Name of your current psychiatrist, psychologist, therapist _____ Last time you saw them _____
17. Name of your current chiropractor or massage therapist _____ Last time you saw them _____
18. How much & type of alcohol do you consume daily _____
19. How much do you use tobacco products daily _____
20. How often & what type of social drugs do you use _____

CIRCLE ALL SYMPTOMS & CONDITIONS YOU HAVE NOW OR EVER HAD IN THE PAST

Anxious	Anger Outburst	Anxiety	Alcoholic or drink too much	High Blood Press
Eating Disorder	Can't sleep or restless	Loss of Hope	Overwhelm	Paranoia
Suicide or hurt yourself	Want to hurt someone else	Irritability to people & things	Low self esteem	Want to die
Headaches or head pain	Neck pain or stiffness	Ringing in your ears	Balance & Dizziness	Dry Mouth
Back pain or muscle spasm	Tingling or numb in hands	Generalized weakness	Rapid or irregular heartbeat	Rapid breathing
Vision problems / eye pain	Tingling or numb in feet	Shortness of breath	Women - hormone problem	Men - erection ED
Depression	Confusion	Suicide thoughts / attempts	Obsess Compulsive OCD	Seizures
Schizophrenia	Migraine Headaches	Autism / ADD / ADHD	Dementia or Forgetfulness	Stroke - CVA
PTSD - Stress Disorder	Metal in your head or neck	Parkinson Disease	Addiction to anything	Vision problems

CIRCLE EVERYTHING BELOW THAT APPLIES TO YOU

Any metal of any kind from an accident, injury or medical / surgical procedure that is in your head, neck, chest or body				
Aneurysm Clips / Coils	Stents, Filters, Heart Valve	Spinal Fluid Shunt	Bone Growth Stimulator	Device Wires
Deep Brain Stimulator	Vagal Nerve Stimulator	Pacemaker or Defibrillator	Dental Implants	Electrodes
Metal in the head/neck	Facial Tattoos w/metal ink	EEG & DBS Electrodes	Infusion Pump	Surgical Staples
Radioactive Seeds	Verichip Micro-transponder	C-Spine plates / screws	Hearing Aids	Eye Glasses
Occular Implants	Cochlear Implants			

PROVIDE INFO ABOUT EACH PSYCHIATRIST OR MENTAL HEALTH PROVIDER YOU SAW OR MENTAL HOSPITAL YOU STAYED IN

DOCTOR OR HOSPITAL NAME	START DATE	TYPE OF TREATMENT	END DATE	CONDITION & RESULTS
(Sample) Dr John Doe	*1994*	*Psychiatrist visits & meds*	*1999*	*Depression results not good*

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MEDICATION REPORT

PATIENT	BIRTHDATE	ALLERGIES TO ANY MEDICATIONS	TODAYS DATE

CIRCLE ALL MENTAL HEALTH MEDICATIONS YOU TAKE NOW OR HAVE EVER TAKEN IN THE PAST & ANSWER ALL QUESTIONS

Abilify	Ativan	Celexa	Cymbalta	Depakote	Edronax	Elavil	Effexor
Lamictal	Latuda	Lexapro	Lithium	Luvox	Pamelor	Paraxetine	Paxil
Geodon	Remerson	Risperdal	Seroquel	Sonata	Thorazine	Trazedone	Trintellix
Valium	Wellbutrin	Xanax	Zoloft	Zyprexa			

Unlisted Mental Health Drugs			
All Medical Drugs You Take			
All Supplements You Take			

ANWER QUESTIONS ABOUT ALL MEDICATIONS & SUPPLEMENTS YOU ARE TAKING NOW OR HAVE EVER TAKEN IN THE PAST

DRUG NAME	START DATE	STOP DATE	SIDE EFFECTS	RESULTS 0 = NO HELP & 10 HELPED

PROVIDE ANY ADDITIONAL INFORMATION ABOUT YOUR MENTAL HEALTH CONDITIONS, TREATMENT & MEDICATIONS

PLEASE USE SEPARATE PAPER TO PROVIDE ADDITIONAL INFORMATION

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DEPRESSION & ANXIETY ASSESSMENT

PATIENT	BIRTHDATE	SCORE PHQ9 BDI GAD7	TODAYS DATE

PATIENT HEALTH QUESTIONNAIRE

please select the answer that best describes you, your current situation or the past 2 weeks 0 = NOT AT ALL 1= SELDOM 2= MORE THAN 1/2 OF THE DAYS 3= NEARLY EVERYDAY	0	1	2	3
PHQ 1. I HAVE INTEREST OR PLEASURE IN DOING THINGS				
PHQ 2. I FEEL DOWN, DEPRESSED OR HOPELESS				
PHQ 3. I HAVE TROUBLE FALLING ASLEEP, STAYING ASLEEP OR SLEEPING TOO MUCH				
PHQ 4. I FEEL TIRED AND HAVE LITTLE ENERGY				
PHQ 5. I HAVE A POOR APPETITE OR I OVER-EAT				
PHQ 6. I FEEL BAD ABOUT MYSELF AND FEEL LIKE I AM A FAILURE AND LET MYSELF OR MY FAMILY DOWN				
PHQ 7. I HAVE TROUBLE CONCENTRATING ON THINGS SUCH AS READING OR WATCHING TELEVISION				
PHQ 8. I MOVE & SPEAK SO SLOWLY & I AM FIDGETY OR RESTLESS SO MUCH THAT OTHER PEOPLE NOTICE				
PHQ 9. I HAVE THOUGHTS THAT I WOULD BE BETTER OFF DEAD OR OF HURTING YOURSELF				

GENERALIZED ANXIETY DISORDER ASSESSMENT

GAD 1. I AM FEELING NERVOUS, ANXIOUS OR ON EDGE				
GAD 2. I AM NOT ABLE TO STOP OR CONTROL MY WORRYING				
GAD 3. I AM WORRYING TOO MUCH ABOUT DIFFERENT THINGS				
GAD 4. I AM HAVING TROUBLE RELAXING MY MIND &/OR MY BODY				
GAD 5. I AM SO RESTLESS THAT IT IS HARD TO SIT STILL OR SLEEP				
GAD 6. I AM BECOMING EASILY ANNOYED AND IRRITABLE WITH THINGS & PEOPLE				
GAD 7. I AM FEELING AFRAID AS IT SOMETHING AWFUL MIGHT HAPPEN TO ME				

BECK DEPRESSION INVENTORY QUESTIONNAIRE - BDI

Q1	**0**	I DO NOT FEEL SAD	**1**	I FEEL SAD REGULARLY	**2**	I AM SAD ALL THE TIME	**3**	I AM SO SAD & CAN'T STAND IT
Q2	**0**	I AM NOT DISCOURAGED ABOUT THE FUTURE	**1**	I AM DISCOURAGED ABOUT THE FUTURE	**2**	I HAVE NOTHING TO LOOK FORWARD TO	**3**	I FEEL THE FUTURE IS HOPELESS
Q3	**0**	I DO NOT FEEL LIKE A FAILURE	**1**	I FEEL I HAVE FAILED MORE THAN THE AVERAGE PERSON	**2**	I HAVE FAILED MANY TIMES IN MY LIFE	**3**	I HAVE TOTALLY FAILED AS A PERSON
Q4	**0**	I ENJOY THINGS JUST AS MUCH TODAY AS IN PAST	**1**	I DON'T ENJOY THINGS THE WAY I USED TO	**2**	I DON'T ENJOY ANYTHING ANYMORE	**3**	I AM DISSATISFIED WITH EVERYTHING
Q5	**0**	I DO NOT FEEL PARTICULARLY GUILTY	**1**	I FEEL GUILTY REGULARLY	**2**	I FEEL GUILTY MOST OF THE TIME	**3**	I FEEL GUILTY ALL OF THE TIME
Q6	**0**	I DO NOT FEEL LIKE I AM BEING PUNISHED	**1**	I FEEL I MAY BE PUNISHED BY SOMEONE FOR SOMETHING	**2**	I EXPECT TO BE PUNISHED FOR SOMETHING	**3**	I FEEL I AM BEING PUNISHED
Q7	**0**	I DO NOT FEEL DISAPPOINTED IN MYSELF	**1**	I AM DISAPPOINTED IN MYSELF	**2**	I AM DISGUSTED IN MYSELF	**3**	I HATE MYSELF
Q8	**0**	I DO NOT FEEL WORSE THAN ANYONE ELSE	**1**	I AM CRITICAL OF MY WEAKNESSES & MISTAKES	**2**	I BLAME MYSELF ALL THE TIME FOR MY FAULTS	**3**	I BLAME MYSELF FOR EVERYTHIING BAD
Q9	**0**	I DON'T HAVE THOUGHTS OF KILLING MYSELF	**1**	I HAVE THOUGHTS OF KILLING MYSELF BUT WON'T DO IT	**2**	I WOULD LIKE TO KILL MYSELF	**3**	I WILL KILL MYSELF IF I HAVE THE CHANCE
Q10	**0**	I DO NOT CRY ANYMORE THAN USUAL	**1**	I CRY NOW MORE THAN I USED TO	**2**	I CRY ALL THE TIME NOW	**3**	I CAN'T CRY EVEN THOUGH I WANT TO
Q11	**0**	I DO NOT GET IRRITATED ANYMORE THAN BEFORE	**1**	I AM SLIGHTLY MORE IRRITATED THAN USUAL	**2**	I GET IRRITATED EASILY & OFTEN FOR NO REASON	**3**	I AM IRRITATED MOST OF THE TMIE
Q12	**0**	I DON'T LOSE INTEREST IN OTHER PEOPLE	**1**	I AM LESS INTERESTED IN OTHERS THAN I USED TO BE	**2**	I HAVE LOST MOST OF MY INTEREST IN OTHERS	**3**	I HAVE LOST ALL INTEREST IN OTHERS
Q13	**0**	I MAKE DECISIONS AS WELL AS I EVER DID	**1**	I PUT OFF MAKING DECISIONS MORE THAN I USED TO	**2**	I HAVE DIFFICULTY MAKING DECISIONS MORE NOW	**3**	I CAN'T MAKE DECISIONS AT ALL
Q14	**0**	I DO NOT FEEL I LOOK ANY WORSE THAN I USED TO	**1**	I WORRY I AM LOOKING UNATTRACTIVE OR OLD	**2**	I FEEL PERMANENT CHANGES MAKE ME UGLY	**3**	I BELIEVE I LOOK UGLY
Q15	**0**	I CAN WORK NOW AS WELL AS I USED TO	**1**	IT TAKES EXTRA EFFORT TO GET STARTED DOING THINGS	**2**	I HAVE TO PUSH MYSELF HARD TO DO ANYTHING	**3**	I CAN'T DO ANY WORK AT ALL
Q16	**0**	I SLEEP AS WELL AS USUAL	**1**	I CAN'T SLEEP AS WELL AS I USED TO	**2**	I WAKE 1-2 HRS EARLIER & CAN'T GO BACK TO SLEEP	**3**	I WAKE UP OFTEN & DONT SLEEP THEN
Q17	**0**	I DON'T GET MORE TIRED THAN USUAL	**1**	I GET TIRED MORE EASILY THAN BEFORE	**2**	I GET TIRED FOR DOING JUST ABOUT ANYTHING	**3**	I AM TOO TIRED TO DO ANYTHING
Q18	**0**	MY APPETITE IS NO WORSE THAN USUAL	**1**	MY APPETITE IS NOT AS GOOD AS IT USED TO BE	**2**	MY APPETITE IS MUCH WORSE NOW	**3**	I HAVE NO APPETITE AT ALL
Q19	**0**	I HAVE NOT LOST ANY WEIGHT RECENTLY	**1**	I HAVE LOST 5+ POUNDS W/O TRYING	**2**	I HAVE LOST 10+ POUNDS W/O TRYING	**3**	I HAVE LOST 15+ LBS W/O TRYING
Q20	**0**	I AM NOT WORRIED ABOUT MY HEALTH	**1**	I WORRY OFTEN ABOUT PHYSICAL SYMPTOMS	**2**	I WORRY ABOUT PHYSICAL PROBLEMS CONSTANTLY	**3**	I OBCESS ABOUT PHYS PROBLEMS
Q21	**0**	I AM JUST AS INTERESTED IN SEX AS BEFORE	**1**	I AM LESS INTERESTED IN SEX THAN BEFORE	**2**	I HAVE ALMOST NO INTEREST IN SEX	**3**	I HAVE LOST ALL INTEREST IN SEX

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