

Patient Name: _____



**TMS Wellness Institute Consultation
& Psychiatric Evaluation**

Authorization # _____

Approved Treatment Dates _____

Intake Performed By: _____

Intake Date: _____

Psych Eval Date: _____ Virtual _____

BI Submitted Date: _____

Pre-Auth Submitted Date _____

MT Scheduled Date: _____

Gender Male ☐ Female ☐ Other ☐

Name: _____

DOB _____ Age _____ Phone Number _____

Email Address _____

Street Address _____

City _____ State _____ Zip _____

How did you hear about our TMS Service?

☐ Website ☐ Flyer ☐ Advertisement ☐ Word of mouth ☐ Other _____

Insurance

Primary _____ Member ID _____

Secondary _____ Member ID _____

Provider Phone # on back of insurance card _____

Cash Pay Patient: ☐ yes ☐ no

Psychiatric Diagnosis: ☐ Depression ☐ Anxiety ☐ Schizophrenia ☐ Bipolar Disorder ☐ Other

NOTES: _____

Service Location: Anniston Birmingham

Patient Name:

MEDICATION TRIALS – PAST & CURRENT

SSRI Citalopram (Celexa), Escitalopram (Lexapro), Fluvoxamine (Luvox), Paroxetine (Paxil), Fluoxetine (Prozac), Sertraline (Zoloft)

SNRI Duloxetine (Cymbalta), Venlafaxine (Effexor), desvenlafaxine (pristiq)

Tricyclic Clomipramine (Anafranil), Amitriptyline (Elavil), Desipramine (Norpramin), Nortriptyline (Pamelor , Aventyl),
Doxepin(Sinequan), Trimipramine (Surmontil), Imipramine (Tofranil), Protriptyline (Vivactil)

MAOI Selegiline (Emsam), Isocarboxazid (Marplan), Phenelzine (Nardil), Tranylcypromine (Parnate)

Miscellaneous Trazodone (Desyrel), Mirtazapine (Remeron), Bupropion (Wellbutrin)

Atypical Aripiprazole (Abilify), Lurasidone (Latuda), Risperdal (Risperidone), Brexpiprazole (Rexulti), Quetiapine (Seroquel)

Newer: Levomilnacipran (Fetzima), Lamotrigine (Lamictal), Vortioxetine (Trintellix, Brintellix), Vilazadone (viibryd), Lithium

Additional antidepressant meds not listed above: _____

Notes: _____

Patient Name:

If the patient has experienced DSE (Direct Side Effects) with any medication, be specific with each side effect. This enhances the ability to receive authorizations.

MEDICATION LIST DETAILS

MEDICATION	DOSAGE	CLASS	START DATE	END DATE	RESULTS

Patient Name:

Psychotherapy History

Have you completed a minimum of 12 sessions of psychotherapy? ☐ yes ☐ no

Therapist or Practice Name LCMHC, LCSW, Psychologist, Psychiatrist	Start Date Of Therapy	End Date Of Therapy	Therapy Session Frequency	CBT, DBT, IPT Psychodynamic	Results of Therapy Sessions

Notes / recommendations regarding therapy:

Who is your PCP?

Who is your

Psychiatrist/Prescriber? _____

Past History of TMS

Has the patient had TMS before? Yes ☐ No ☐ If yes, where? _____

When? _____ Did you complete the treatments? ☐ yes ☐ no

Patient Name:

CONTRADINDICATION CHECKLIST

Do you have any non-removal metal objects in/around your head? Yes ☐ No ☐

Cochlear/eye implants Yes ☐ No ☐

Tattoos w/ magneto-sensitive ink Yes ☐ No ☐

Aneurysm clips/coils/stents Yes ☐ No ☐

Cervical fixation device Yes ☐ No ☐

Implanted electrodes Yes ☐ No ☐

Bullet fragments Yes ☐ No ☐

Implanted stimulators Yes ☐ No ☐

VeriChip Microtransponder Yes ☐ No ☐

Implanted plates Yes ☐ No ☐

Tracheostomy Yes ☐ No ☐

Pacemakers/Defibrillators Yes ☐ No ☐

Medication/Nicotine patch Yes ☐ No ☐

Implanted Insulin Pump Yes ☐ No ☐

Other _____

Additional questions

Do you experience any tremors? Yes ☐ No ☐

Have you ever been a machinist, welder, or metal worker? Yes ☐ No ☐

Have you ever had a facial injury from metal and/or metal removed from your eyes? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Have you ever had complications from an MRI? Yes ☐ No ☐

Do you have any Neurological Disorders? (ex: Stroke, Parkinson's, History of Seizures) Yes ☐ No ☐

Notes: _____

Patient Name:

History of Depressive Symptoms / Personal & Family

Age or year of onset: _____

Length of Current Depressive Episode

History of Suicidal Thoughts or History Yes ☐ No ☐

History of Psychiatric Hospitalization Including Dates

Do You Have any Serious Illnesses? Yes ☐ No ☐

History of ECT Including Dates

Chronic Pain – Describe any sources of chronic pain

Circle those with issues: Sleep Memory Appetite

Substance Use – Circle all that apply

CBD - THC - Opiates - Herbs - Barbiturates - ETOH - OTC Inhalants - Steroids - Other

Patient Name:

Mood Reaction to Life Stressors

Spiritual Life – Important Yes ☐ No ☐

Support System – AA, Al-Anon, Church, Family, Friends, Etc.

ADDITIONAL NOTES: