Empower Psychiatry & Sleep LLC.
Suwanee, GA 30024
Tel: 770-615-0226

Pre-screen for TMS and/or nasal Esketamine (Spravato)

Name:_____ **Date**_____ **DOB**:_____

When did you first have depression in your lifetime? _____

How long have you had current depressive symptoms? _____

Were you diagnosed with OCD ____ If Yes, how long have you had OCD_____

Did you ever have suicidal thoughts? _____ If Yes, when _____

Do you have suicidal thoughts currently? _____

Please list the **medications** that you have been on for depression.

	Name	Maximum dosage	Date range / if you do not recall - please put approximate date range (e.g.1/2018-6/2018)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

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Did you have **talk therapy**/**psychotherapy**? ____ If yes, please list dates/duration and number sessions.

Please specify if any of the therapies you had was CBT (Cognitive Behavioral Therapy)

	Therapist - Name/Credentials	Date range (e.g.1/2018-6/2018)	Type of Therapy
1			
2			
3			
4			
5			

Have you ever received ECT? _____ If Yes, when_____ & how many treatments_____

Have you ever had TMS before? ___ If Yes, when _____& how many treatments _____

Have you ever had Ketamine? _____ If Yes, when_____

Have you ever had Spravato (Esketamine treatments)? _____, if Yes, when_____

Please list any other medications or other treatments for depression that you had in your lifetime.

1	
2	
3	
4	
5	
6	
7	

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Have you ever had a manic or hypomanic episode in your lifetime? _____ If yes, please describe_____

Did you ever have any psychotic symptoms such as hearing voices or seeing things that are not there or being excessively paranoid? _____ If yes, please describe_____

Do you have any of the following:

1. Magnetic substance or metal in your head or neck area Yes___ / No____
2. Ever had seizures Yes___ / No____
3. Any of your family members have seizures Yes___ / No____
4. Ever had a stroke/ hemorrhagic stroke Yes___ / No____
5. Poorly controlled blood pressure Yes___ / No____
6. Allergic reaction during anesthesia Yes___ / No____
7. Hypersensitive to Ketamine or related substances Yes___ / No____
8. Are you pregnant or planning pregnancy Yes___ / No____
9. Any aneurysm clips or coils in the head or neck Yes___ / No____
10. Ever had severe head trauma Yes___ / No____
11. Hearing problems or ringing in your ears Yes___ / No____
12. Ever undergo MRI in the past Yes___ / No____
13. Have cochlear implants Yes___ / No____
14. Severe or recent heart disease Yes___ / No____
15. Have any aneurysms or arteriovenous malformations Yes___ / No____
16. Had intracerebral hemorrhage Yes___ / No____
17. Do you suffer from frequent or severe headaches Yes___ / No____