Pre-screen for TMS

Name:____________________________ Date_____________
DOB:_____________________________

When did your first have depression in your lifetime?

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

Do you have suicidal thoughts currently? ______

How long have you had current depressive symptoms? ___________________
Please indicate likely month/year of onset (approximate) of current depressive symptoms
____

Please list the **medications** that you have been on for the current depressive symptoms.

	Name	Maximum dosage	Date range (e.g.1/30/18-6/11/18)	Response
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

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

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

	Date range (e.g.1/30/18-6/11/18)	Therapist	Type of Therapy - response
1			
2			
3			
4			
5			

Have you ever been on ECT? ________ If Yes, when and how many treatments__________

Have you ever had TMS before? _______ If Yes, when/ number of treatments ___________
If you had TMS before, did you have a response at that time - Yes/ No

Have you ever had Ketamine? _______ If Yes, when________________________________

Other:

Please list any other medications or other treatments for depression that you had in your lifetime.
1.
2.
3.
4.
5.
6.
7.

Did you ever have a manic or hypomanic episode in your life time? _____ 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____