

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			

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	

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___ |