TRUE NORTH TMS
AT WILLOW MEDICAL

Intake Form

Name: _____ Date of Birth: _____ Date: _____

Please complete all information on this form and return it to the office 3 days prior to your appointment

Primary Care Physician: _____ Current Counselor: _____

Current Psychiatric Provider: _____

What are the problem(s) you are seeking help for?_____

Current major life stressors: _____

Current Symptoms Checklist (*Check the box for any symptoms present*)

☐ Depressed mood
☐ Lack of pleasure
☐ Weight loss/gain
☐ Sleep disturbances
☐ Fatigue/loss of energy
☐ Worthlessness/excessive guilt
☐ Decreased ability to think/concentrate/indecisiveness
☐ Recurrent thoughts of death/suicidal ideation
☐ Homicidal ideation
☐ Crying spells
☐ Hopelessness/Helplessness
☐ No motivation
☐ Seasonal component
☐ Decreased libido

☐ Mania/hypomania
☐ Significant mood swings
☐ Elevated mood
☐ Elevated self-esteem
☐ Increased irritability
☐ Increased impulsivity
☐ Increased risk-taking behavior
☐ Decreased need for sleep
☐ Hyper talkative
☐ Racing thoughts
☐ Increased goal directed activity
☐ Grandiose thinking

Frequency of manic/hypomanic episode:

☐ Auditory or visual hallucinations ☐ Paranoid thinking ☐ Suspicious of other

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☐ Anxiety
☐ Worry about:_____
☐ Panic episodes - Lasts for how long: _____ Occurs every: _____
☐ Obsessive thoughts: _____
☐ Compulsive behaviors (checking/counting): _____
☐ Nightmare/flashbacks
☐ Fears of social situations
☐ Specific fears: _____

☐ Problems with attention ☐ Distractibility ☐ Hyperactivity ☐ Impulsivity

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Personal Psychiatric History (*Please check all applicable boxes if you have ever experienced issues related to the following)*

□ **Depression**

***When were you first diagnosed with depression*:**_____

***Duration of your current episode of depression*:**_____

□ Bipolar

□ Anxiety

□ OCD

□ Schizophrenia

□ ADHD

□ Developmental/LD

□ Eating Disorder

□ Substance Abuse

□ Suicidal Thoughts

Past Psychiatric History

Inpatient treatment: □No □Yes - Where/When/Reason:_____

Outpatient treatment: □No □Yes - Where/When/Reason: _____

Prior treatment with psychotherapy: □ No □ Yes - Where/When/Reason: _____

Prior treatment with: □ TMS □ ECT □ Other: _____

Any suicide attempts: □ No □ Yes - When: _____

Current Medications (List *ALL* currently prescribed medications)

_____

_____

_____

List ALL current over the counter medications or supplements: _____

_____

Allergies: _____

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Past Psychiatric Medications (Please list the dosage, dates, response, and side effects associated)

SSRIs		Dosage	Start Date/ End Date	Response	Side Effects
Prozac (fluoxetine)	☐				
Paxil (paroxetine)	☐				
Zoloft (sertraline)	☐				
Celexa (citalopram)	☐				
Lexapro (escitalopram)	☐				
Luvox (fluvoxamine)	☐				
SNRIs					
Effexor (venlafaxine)	☐				
Cymbalta (duloxetine)	☐				
Pristiq (desvenlafaxine)	☐				
Fetzima (levomilnacipran)	☐				
Other					
Wellbutrin (bupropion)	☐				
Remeron (mirtazapine)	☐				
TCAs/TeCAs					
Anafranil (clomipramine)	☐				
Pamelor (nortptyline)	☐				
Tofranil (imipramine)	☐				
Elavil (amitriptyline)	☐				
Vivactil (protriptyline)	☐				
Serotonin Modulators					
Viibryd (vilazodone)	☐				
Serzone (nefazodone)	☐				
Trintellix (vortioxetine)	☐				
MAOIs					
Emsam (selegiline)	☐				
Parnate (tranylcypromine)	☐				

Nardil (phenelzine)	☐				
Mood Stabilizers					
Tegretol (carbamazepine)	☐				
Trileptal (oxcarbazepine)	☐				
Lithium	☐				
Depakote (valproate)	☐				
Lamictal (lamotrigine)	☐				
Neurontin (gabapentin)	☐				
Topamax (topiramate)	☐				
Antipsychotics / Mood Stabilizers		Dose	Dates	Response	Side Effects
Haldol (haloperidol)	☐				
Clozaril (clozapine)	☐				
Zyprexa (olanzapine)	☐				
Seroquel (quetiapine)	☐				
Risperdal (risperidone)	☐				
Abilify (aripiprazole)	☐				
Geodon (ziprasidone)	☐				
Saphris (asenapine)	☐				
Latuda (lurasidone)	☐				
Rexulti (brexpiprazole)	☐				
Vraylar (cariprazine)	☐				
Fanapt (iloperidone)	☐				
Invega (paliperidone)	☐				
Sedative/Hypnotics					
Ambien (zolpidem)	☐				
Sonata (zaleplon)	☐				
Lunesta (eszopiclone)	☐				
Rozerem (ramelteon)	☐				
Restoril (temazepam)	☐				

Desyrel (trazodone)	☐				
Belsomra (suvorexant)	☐				
ADHD Medications					
Ritalin (methylphenidate)	☐				
Concerta (methylphenidate)	☐				
Focalin (dexmethylphenidate)	☐				
Dexedrine (dextroamphetamine)	☐				
Vyvanse (lisdexamfetamine)	☐				
Adderall (amphetamine)	☐				
Strattera (atomoxetine)	☐				
Intuniv (guanfacine)	☐				
Anti anxiety medications					
Xanax (alprazolam)	☐				
Xanax XR	☐				
Ativan (lorazepam)	☐				
Klonopin (clonazepam)	☐				
Valium (diazepam)	☐				
Tranxene (clorazepate)	☐				
Buspar (buspirone)	☐				
Other	☐				
	☐				

Current Medical Problems_____

_____

_____

Personal Medical History

☐ Seizures
☐ Thyroid Disorder
☐ Diabetes
☐ Heart Disease
☐ Cancer
☐ Head Injury with LOC Concussion
☐ Seizures
☐ Stroke
☐ Hypertension
☐ Cardiovascular Disease
☐ Arrhythmias
☐ Sleep Disorder
☐ Endocrine
☐ Pulmonary
☐ Musculoskeletal Disorder
☐ GI/Liver Disease
☐ Renal Disease
☐ Anemia, Coagulation Disorder
☐ Pregnant

Date of last Physical Exam: _____

Past Surgeries

_____

_____

Other Medical Information for TMS

Magnetic-sensitive metal in their head or within 12 inches (30 cm) of the NeuroStar magnetic coil that cannot be removed:

☐ Cochlear implants
☐ Aneurysm clips or coils
☐ Stents
☐ Electrodes to monitor your brain activity
☐ Ferromagnetic implants in your ears or eyes
☐ Bullet fragments
☐ Other metal devices/objects implanted in the head
☐ Facial Tattoos/Permanent makeup

Implanted stimulators in or near the head:

☐ Deep brain stimulators
☐ Vagus nerve stimulators
☐ Cochlear implants

Family Psychiatric History

☐ Depression
☐ Bipolar
☐ Anxiety
☐ OCD
☐ Schizophrenia
☐ ADHD
☐ Developmental/LD
☐ Eating Disorder
☐ Substance Abuse
☐ Suicide

Family Medical History

☐ Seizures
☐ Thyroid Disorder
☐ Diabetes
☐ Heart Disease
☐ Cancer
☐ Head Injury with LOC/ Concussion

☐ Seizures
☐ Stroke
☐ Hypertension
☐ Cardiovascular Disease
☐ Arrhythmias
☐ Sleep Disorder
☐ Endocrine

☐ Pulmonary
☐ Musculoskeletal Disorder
☐ GI/Liver Disease
☐ Renal Disease
☐ Anemia, Coagulation Disorder
☐ Other:

Substance Use *(Check all applicable boxes and describe amount/frequency of use)*

☐ Caffeine
☐ Tobacco
☐ Alcohol
☐ Opiates
☐ Stimulants
☐ IV Drug Use/Illicit drug use
☐ Cocaine/Amphetamines
☐ Other:

Have you ever felt you ought to cut down on your drinking or drug use: ☐Yes ☐No

Have people criticized your drinking or drug use: ☐Yes ☐ No

Have you felt guilty about your drinking or drug use: ☐ Yes ☐No

Have you ever had a drink/used drugs in the morning to steady your nerves/rid a hangover: ☐ Yes ☐ No

Have you been treated for alcohol or drug use: ☐Yes ☐No

If yes, which substance: _____

Where and when were you treated: _____

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Family Background and Childhood History

Where were you born and raised?

_____

Father's occupation: _____ Mother's occupation: _____

Sibling's gender/ages:_____

Did your parents divorce? ☐ No ☐ Yes - How old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Education History: Did you enjoy school? _____How far in school did you go? _____

Has anyone in your immediate family died? ☐ No ☐ Yes - Who/When: _____

Trauma History: Do you have a history of being mistreated emotionally, sexually, physically, or neglected? ☐ No ☐ Yes

Relationship History and Current Family

Are you currently:☐ Married ☐ Divorced ☐ Single ☐ Widowed How long: _____

If not married, are you currently in a relationship? ☐ No ☐ Yes - How long: _____

Do you have any children: ☐ No ☐ Yes - Gender/ages of children: _____

_____

Describe your relationship with your spouse/children: _____

List everyone who currently lives with you: _____

Occupational History: Are you currently: ☐ Working ☐ Unemployed by choice ☐ Unemployed ☐ Disabled ☐ Retired How long in present position: _____

What is/was your occupations? _____ Where do you work? _____

Served in the military: ☐ No ☐ Yes - What branch and when: _____

Legal: Have you ever been arrested? ☐ No ☐ Yes:_____

Do you have any pending legal problems? ☐ No ☐ Yes:_____

Spiritual Life: Do you belong to a religion or spiritual group? ☐ No ☐ Yes:_____

Primary Support Person: _____

Signature: _____ Date: _____