



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

-
- Mania/hypomania
 - Increased risk-taking behavior
 - Significant mood swings
 - Decreased need for sleep
 - Elevated mood
 - Hyper talkative
 - Elevated self-esteem
 - Racing thoughts
 - Increased irritability
 - Increased goal directed activity
 - Increased impulsivity
 - Grandiose thinking
- Frequency of manic/hypomanic episode: _____

-
- Auditory or visual hallucinations
 - Paranoid thinking
 - Suspicious of others

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



TRUE NORTH TMS
AT WILLOW MEDICAL

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: _____



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

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



TRUE NORTH TMS
AT WILLOW MEDICAL

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



TRUE NORTH TMS
AT WILLOW MEDICAL

Desyrel (trazodone)	<input type="checkbox"/>				
Belsomra (suvorexant)	<input type="checkbox"/>				
ADHD Medications					
Ritalin (methylphenidate)	<input type="checkbox"/>				
Concerta (methylphenidate)	<input type="checkbox"/>				
Focalin (dexmethylphenidate)	<input type="checkbox"/>				
Dexedrine (dextroamphetamine)	<input type="checkbox"/>				
Vyvanse (lisdexamfetamine)	<input type="checkbox"/>				
Adderall (Dextroamphetamine/amphetamine)	<input type="checkbox"/>				
Strattera (atomoxetine)	<input type="checkbox"/>				
Intuniv (guanfacine)	<input type="checkbox"/>				
Anti Anxiety Medications					
Xanax (alprazolam)	<input type="checkbox"/>				
Xanax XR	<input type="checkbox"/>				
Ativan (lorazepam)	<input type="checkbox"/>				
Klonopin (clonazepam)	<input type="checkbox"/>				
Valium (diazepam)	<input type="checkbox"/>				
Tranxene (clorazepate)	<input type="checkbox"/>				
Buspar (buspirone)	<input type="checkbox"/>				
Other	<input type="checkbox"/>				
	<input type="checkbox"/>				

Current Medical Problems _____



Personal Medical History

- | | | |
|--|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> GI/Liver Disease |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Renal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Anemia, Coagulation Disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Sleep Disorder | |
| <input type="checkbox"/> Head Injury with LOC Concussion | <input type="checkbox"/> Endocrine | |
| <input type="checkbox"/> Musculoskeletal Disorder | <input type="checkbox"/> Pulmonary | |

Date of last Physical Exam: _____

Past Surgeries

Other Medical Information for TMS

Do you have any of the following magnetic sensitive items in or around your head?

- | | |
|--|--|
| <input type="checkbox"/> Cochlear implants | <input type="checkbox"/> Ferromagnetic implants in your ears or eyes |
| <input type="checkbox"/> Aneurysm clips or coils | <input type="checkbox"/> Bullet fragments |
| <input type="checkbox"/> Stents | <input type="checkbox"/> Other metal devices/objects implanted in the head |
| <input type="checkbox"/> Electrodes to monitor your brain activity | <input type="checkbox"/> Facial Tattoos/Permanent makeup |

Implanted stimulators in or near the head:

- | | |
|---|--|
| <input type="checkbox"/> Deep brain stimulators | <input type="checkbox"/> Vagus nerve stimulators |
| <input type="checkbox"/> Cochlear implants | |

Family Psychiatric History

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> ADHD | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Developmental/LD | |
| <input type="checkbox"/> OCD | <input type="checkbox"/> Eating Disorder | |



Family Medical History

- | | | |
|--|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Pulmonary |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Musculoskeletal Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> GI/Liver Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Renal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Anemia, Coagulation Disorder |
| <input type="checkbox"/> Head Injury with LOC/
Concussion | <input type="checkbox"/> Endocrine | <input type="checkbox"/> 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: _____



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 occupation? _____ 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 religious or spiritual group? No Yes: _____

Primary Support Person: _____

Signature: _____ Date: _____