TMS Consult:

TMS stands for "Transcranial Magnetic Stimulation". TMS uses specialized magnetic pulses to help stimulate and regulate areas of the brain that are affected by depression. Treatment sessions are completed daily, Monday through Friday, to achieve best results. Sessions last anywhere from twenty-five to forty-five minutes. Most insurances will cover TMS after submitting a prior authorization. The more information you are able to provide on this form, the more efficiently we can begin your TMS treatments. Please complete the following sections in as much detail as possible.

Medications-

Please fill out the chart below with as much information as possible regarding your **current psychiatric medications**.

Medication Name- Brand name or generic.	**Maximum Dosage**- Dosage you are taking.	**Dates Taken**- Roughly when you started taking this medication.
Ex. Prozac	Ex. 40 MG twice a day	Ex. 06/14/20- current

Please fill out the chart below with as much information as possible regarding your **previous psychiatric medications.**

Medication Name- Brand name or generic.	**Maximum Dosage-** Max dosage you have ever taken.	**Dates taken-** roughly when did you start and stop taking this medication.	**Reason for Discontinuing-** please list any side effects or reasons to discontinue taking this medication.
Ex. Cymbalta	Ex. 60 MG twice a day	Ex. 06/14/20-09/12/22	Ex. Blurred vision and upset stomach

Example Medications: Prozac, Cymbalta, Zoloft, Paxil, Effexor, Escitalopram, Sertraline, Duloxetine, etc.

Please use this space for any other psychiatric medications not listed in the charts above.

Medication Name-	Maximum Dosage-	Dates Taken-	Side effects-

Therapist Information- If you have ever seen a therapist in the past, please answer the questions below in as much detail as possible.

Type of therapy (Ex.- CBT, Talk Therapy):_____

Therapist's Name: _____

Dates you saw therapist between: _____

How often you had appointments (Ex.- once a week, once a month): _____

How well the therapy helped your symptoms (Ex.-not at all, somewhat, a lot): _____

Other General Questions- Please check the box if you have had a history of any of the following.

- ☐ History of seizures
- ☐ History of surgery or injury to the head or brain
- ☐ Cochlear Implants
- ☐ Aneurysm clips or coils
- ☐ Stents
- ☐ Implanted stimulators
- ☐ Electrodes to monitor brain activity
- ☐ Any ferromagnetic implants in the head or neck
- ☐ Metal plates or fragments in the head or neck

For office use only:

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