New TMS Patient Paperwork

Name:_____ DOB:_____

Gender: _____Primary Phone #: _____ Secondary Phone: _____

Address:_____

_____Zip Code:_____ Email:_____

Primary Care Physician: _____

Preferred Square Medical Location (circle one): Watertown Weymouth Woburn

Completed by (if other than patient): _____ Relationship: _____

During a typical week, when is the best time to contact you? Please circle what applies:

Mornings: M T W TR F Mid-day: M T W TR F Afternoons: M T W TR F

Insurance:

Primary Insurance:_____Policy #:_____

Plan Name:_____Group Name:_____

Start Date: _____

(If same as patient, leave blank)

Subscriber Name:_____DOB: _____

Address: _____ Zip Code:_____

Relationship: _____ Gender: _____

Secondary Insurance:_____Policy #:_____

_____Plan Name:_____

Group Name:_____ Start Date:_____

(If same as patient, leave blank)

Subscriber Name:_____DOB: _____

Address: _____ Zip Code:_____

Relationship: _____ Gender: _____

Contra-indication Questions:

Please respond to the following questions. If any of the following apply, include a description of condition or history in the provided space AND inform your TMS Coordinator. TMS may not be insurance-approved under the following conditions.

Do you have any metal implants in your head, neck, or face area? Y / N
If yes, is the metal MRI-safe? Y / N / Unknown
Please provide details: _____

Do you have a history of seizures or a seizure disorder? Y / N
If yes, please provide details:

_____

Do you have any implants such as a deep brain stimulator, vagus nerve stimulator or a pacemaker? Y / N
If yes, please provide details:

_____

Are you currently pregnant, or planning to be pregnant? Y / N

Are you currently or have you ever been diagnosed with bipolar disorder? Y / N
If yes: When were you diagnosed? _____
When was the last manic episode? _____

Are you currently or have you ever experienced psychotic symptoms such as hallucinations or paranoia? Y / N
If yes, please provide details:

_____

Do you have a history of severe head trauma, dementia, or tumors in the Central Nervous System (brain)? Y / N
If yes, please provide details:

_____

Do you have history of illegal drug use, substance use disorders, alcoholism, or “active addiction”? Y / N
If yes, do you currently have at least 3 months of sobriety / maintenance? Y / N

Current psychiatric/psychological treatment:

Psychiatrist(s): _____ Treatment: _____

Start Date: _____ End Date: _____ Frequency: _____

Counselor/Therapist(s): _____ Treatment: _____

Start Date: _____ End Date: _____ Frequency: _____

Additional prior psychiatric/psychological treatment:

Psychiatrist(s): _____ Treatment: _____

Start Date: _____ End Date: _____ Frequency: _____

Counselor/Therapist(s): _____ Treatment: _____

Start Date: _____ End Date: _____ Frequency: _____

Other psychological programs/treatment (groups, outpatient programs, etc.):

_____

_____

Current Diagnosis of F33.2 (Recurrent MDD, Severe, w/o Psychotic Symptoms) **or F32.2** (MMD, Single Episode, Severe, w/o Psychotic Symptoms) **(circle one)**

Past Treatment:

Have you received TMS treatment in the past? Y / N

IF yes: Where: _____ Dates: _____

Was it successful in helping your depression symptoms? Y / N

Have you received ECT treatment in the past? Y / N

IF yes: Where: _____ Dates: _____

Was it successful in helping your depression symptoms? Y / N

Please list current and past anti-depressant medications. If you are unsure of the dates of the medication trial, please approximate the month and year as best as possible.

SSRIs

Brand Name	Generic Name	Dose	Start Date	End Date	Reason Stopped
Celexa	Citalopram				
Lexapro	Escitalopram				
Luvox	Fluvoxamine				
Luvox CR	Fluvoxamine CR				
Prozac	Fluoxetine				
Zoloft	Sertraline				
Paxil	Paroxetine				
Paxil CR	Paroxetine CR				

SNRIs

Brand Name	Generic Name	Dose	Start Date	End Date	Reason Stopped
Cymbalta	Duloxetine				
Effexor	Venlafaxine				
Effexor XR	Venlafaxine XR				
Pristiq	Desvenlafaxine				
Savella	Milnacipram				
Fetzima	Lavomilnacipram				

Atypical

Brand Name	Generic Name	Dose	Start Date	End Date	Reason Stopped
Oleptro	Trazodone				
Remeron	Mirtazapine				
Serzone	Nefazadone				
Wellbutrin SR	Bupropion SR				
Wellbutrin XL	Bupropion XL				
Desyrel	Trazodone				
Viibryd	Vilazodone				
Trintellix	Vortioxetine				
Spravato	Esketamine				
Zulresso	Brexanolone				

Tricyclic

Brand Name	Generic Name	Dose	Start Date	End Date	Reason Stopped
Anafranil	Clomipramine				
Asendin	Amoxapine				
Elavil	Amitriptyline				
Norpramin	Desipramine				
Pamelor	Nortriptyline				
Sinequan	Doxepin				
Surmontil	Trimipramine				
Tofranil	Imipramine				
Ludiomil	Maprotiline				
Vivactil	Protriptryline				

MAOI

Brand Name	Generic Name	Dose	Start Date	End Date	Reason Stopped
Emsam	Segeline				
Marplan	Isocarbozazid				
Nardil	Phenelzine				
Parnate	Tranylcypromine				

Augmenting Agents

Brand Name	Generic Name	Dose	Start Date	End Date	Reason Stopped
Abilify	Aripiprazole				
BuSpar	Buspirone				
Seroquel	Quetiapine				
Rexulti	Brexpiprazole				
Risperdal	Risperidone				
Geodon	Ziprasidone				
Zyprexa	Olanzapine				
Lithobid	Lithium				
Lamictal	Lamotrigine				
Topamax	Topiramate				
Triiodothyronine					
Zyprexa	Olanzapine				

Antidepressant Medication not listed above:

Brand Name	Generic Name	Dose	Start Date	End Date	Reason Stopped

Please sign below to affirm that you have answered the above questions with clarity and accuracy, to the best of your knowledge.

Thank you for taking the time to fill out our Patient Questionnaires. This information will help us to prepare the Prior Authorization documents for your insurance, and to prepare you for Transcranial Magnetic Stimulation treatment. Please return/submit this document when it is complete and reach out to your local office Coordinator with any questions or more information.