New Patient Form - Eastside TMS

New Patient Packet

1. Patient & Billing Information:

First Name: _____ Middle Name: _____ Last Name: _____

Birthdate: _____

Gender:
- ○ Male
- ○ Female
- ○ Nonbinary
- ○ Genderfluid

Preferred pronouns?
- ☐ He/him/his ☐ She/her/hers
- ☐ They/them/theirs ☐ Other

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____ Employer: _____

Work Phone: _____ Emergency Contact: _____

Relationship: _____ Phone: _____ Preferred name? (If different from legal name) _____

2. Please upload a copy/image of your photo identification card.

3. Please upload a copy/image of your insurance identification card(s) - front and back.

4. Primary Insurance Information:

Primary Insurance: _____ ID Number: _____ Group Number: _____

Primary Insured: _____ Birthdate: _____

Relationship to Patient:
○ Self ○ Spouse ○ Child ○ Other

5. Secondary Insurance Information:

Secondary Insurance: ID Number: Group Number:

Secondary Insured: Birthdate:

Social Security Number: Relationship to Patient:
○ Self ○ Spouse ○ Child ○ Other

6. **Have you contacted your insurance company and verified your eligibility for mental health benefits:?**

○ Yes ○ No

Patient Signature

Signature

Patient History:

This form is to save you and your practitioner's time in the interest of providing you with the best service possible. All information on this form is considered confidential. Please answer as carefully and completely as possible.

7. Date:

Referred by: Primary Physician:

About Your Current Problems:

8. **List the problems of greatest concern to you:**

9. **Describe the problems in your own words:**

10. Prior psychiatric, psychological, or chemical dependency services:

	Inpatient/Outpatient	Practitioner Seen	Date of Service	Were Services Helpful?
1				
2				
3				

11. Therapy History:

	Therapist's Name	Start Date Month/Year	End Date Month/Year	How often were sessions?

Substance Abuse History:

12. Please indicate yes or no to the following:

	Yes	No
Have you ever felt you should cut down on your drinking/drug use?		
Have people annoyed you by criticizing your drinking/drug use?		
Have you ever felt bad or guilty about your drinking/drug use?		
Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover?		

Family Medical, Psychiatric & Chemical Dependency History:

13. Please specify if these conditions are current or have occurred in relatives:

	Children	Siblings	Mother	Father	Uncle/Aunts	Grandparents	Others
Nervous Problems (Anxiety)							
Depression							
Psychiatric Treatment							
Drinking Problems							
Medical Conditions							
Drug Abuse							
Medical Treatment							
Other							

Specify if other:

_____

14. Have you had a problem/diagnostic/treatment procedure regarding any of the following?

	Current	Past
Shortness of breath		
Asthma		
Coughing up blood		
Joint/ back problems		
Bleeding from any part of the body		
Unintentional weight loss/gain		
Chest pain/palpitation		
High blood pressure		
Infection		
Diabetes		
Stroke		
Kidney disease/stones		
Sudden loss of smell, taste, vision, hearing, sensation		
Thyroid/gland problems		
Convulsions/seizures		
Arthritis		
Motor coordination/paralysis		
Tuberculosis/exposure		
Hormone replacement therapy		
Cancer (within the past 5 years)		
Frequent lingering cough		
Heart disease		
Anemia		
Night sweats/fevers		
Ulcers		
Dizziness/fainting spells		
Epilepsy		
Pain in back or extremities		
Skin problems		
Jaundice/hepatitis		
Nutrition problems		
Increased thirst/urination		

Smoking		
Abdominal pain		
Drugs		
Eating disorder		
Alcohol		
Surgery/injuries		
Frequent/severe headaches		
Other		
None		

15. Adverse/ allergic drug reactions:

16. All Past and Present Medications. TMS Patients MUST included Date of Start and Stop Trials and Dosage in next section

- ☐ Escitalopram (Lexapro)
- ☐ Fluoxetine (Prozac)
- ☐ Sertraline (Zoloft)
- ☐ Venlafaxine (Effexor)
- ☐ Desvenlafaxine (Khedezla, Pristiq)
- ☐ Duloxetine (Cymbalta)
- ☐ Bupropion (Wellbutrin, Wellbutrin XL)
- ☐ Esketamine (Spravato)
- ☐ Mirtazapine (Remeron)
- ☐ Vilazodone (Viibryd)
- ☐ Vortioxetine (Trintellix)
- ☐ Citalopram (Celexa)
- ☐ Paroxetine (Paxil)
- ☐ Buspirone (Buspar)
- ☐ Lamotrigine (Lamictal)
- ☐ Lithium
- ☐ Pregabalin (Lyrica)
- ☐ Aripiprazole (Abilify)
- ☐ Brexpiprazole (Rexulti)
- ☐ Quetiapine (Seroquel)
- ☐ Eszopiclone (Lunesta)
- ☐ Doxepin (Silenor)
- ☐ Zalepon (Sonata)
- ☐ Zolpidem (Ambien)
- ☐ Propranolol (Inderal)
- ☐ Prazosin (Minipress)
- ☐ Ritalin
- ☐ Adderal
- ☐ Dexedrine
- ☐ Vyvanse
- ☐ Focalin
- ☐ Concerta
- ☐ Guanfacine
- ☐ Provigil (Modafinil)
- ☐ Clonidine
- ☐ Atomoxetine (Strattera)
- ☐ None

17. Details of medication from above section or to add medications not listed

	Name of Medication	Dosage	Frequency Taken	Start Month & Year	Stop Month & vYear or N/A for current	Reason for Use/Discontinution
1						
2						
3						
4						
5						
6						

18. Alternative medications/vitamins:

_____

_____

_____

_____

Relationship History:

19. Place of birth:

_____

20. Family Data—Father:

Living?
○ Yes ○ No

Age if living: _____

If deceased, cause of death: _____

Occupation: _____

Health Status: _____

Frequency and Nature of Contact: _____

21. Family Data—Mother:

Living?
○ Yes ○ No

Age if living: _____

If deceased, cause of death: _____

Occupation: _____

Health Status: _____

Frequency and Nature of Contact: _____

22. Family Data—Brothers & Sisters:

	Name	Sex	Age	Residing in
1				
2				
3				

23. Did you live with anyone other than your natural parents for any significant amount of time during your childhood years?

○ Yes ○ No

24. Martial Status:

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed
○ Partnered

If married, re married or partnered, for how long? _____

If divorced, separated, or widowed, for how long? _____

If previously married or in a long-term relationship, when? _____

25. Current Spouse/Partner's Age: _____ Occupation: _____ Any previous marriages? ○ Yes ○ No

26. Spouse/Partner's Prior Marriages:

	When	How Long?
1		
2		
3		

27. Family Data—Children/Stepchildren:

	Name	Sex	Age	Residing in
1				
2				
3				

Living Arrangements/Home Environments:

28. With whom do you currently live?

Education:

29. Highest level of education completed:

30. Did you receive any special educational services?

Occupational History:

31. Work History:

	Position	Employer	Years Worked
1			
2			
3			

Patient Health Questionnaire:

32. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or over eating				
Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				

33. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

Mood Disorder Questionnaire:

34. Has there ever been a period of time when you were not your usual self and...

	Yes	No
you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
you were so irritable that you shouted at people or started fights or arguments?		
you felt much more self-confident than usual?		
you got much less sleep than usual and found you didn't really miss it?		
thoughts raced through your head or you couldn't slow your mind down?		
you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
you had much more energy than usual?		
you were much more active or did many more things than usual?		
you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
you were much more interested in sex than usual?		
you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
spending money got you or your family in trouble?		

35. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

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36. How much of a problem did any of these cause you–like being unable to work; having family, money or legal troubles, getting into arguments or fights?

- ○ Not a problem
- ○ Minor problem
- ○ Moderate problem
- ○ Serious problem

The Generalized Anxiety Disorder 7-Item Scale:

37. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Trouble concentrating on				

38. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

Adults ADHD Self-Report Scale (ARS-V1.1) Symptom Checklist:

39. Please answer the questions below, rating yourself on each of the criteria shown. Choose the answer that best describes how you have felt and conducted yourself over the past 6 months.

Part A	Never	Rarely	Sometimes	Often	Very Often
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					

40. Please answer the questions below, rating yourself on each of the criteria shown. Choose the answer that best describes how you have felt and conducted yourself over the past 6 months.

Part B	Never	Rarely	Sometimes	Often	Very Often
How often do you make careless mistakes when you have to work on a boring or difficult project?					
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or work?					
How often are you distracted by activity or noise around you?					
How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
How often do you feel restless or fidgety?					
How often do you have difficulty unwinding and relaxing when you have time to yourself?					
How often do you find yourself talking too much when you are in social situations?					
When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
How often do you have difficulty waiting your turn in situations when turn taking is required?					
How often do you interrupt others when they are busy?					

41. File Attachments: