TRUE NORTH
INTEGRATIVE MENTAL HEALTH

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1. Who referred you for TMS therapy?

_____

_____

_____

_____

2. May we contact this person and if so please list the phone number.

- ○ Yes
- ○ No

3. For which symptoms are you seeking TMS

- ○ Major depressive symptoms
- ○ Obsessive compulsive symptoms
- ○ Depression with anxiety

4. Have you experienced any of the following?

- ☐ a seizure
- ☐ diagnosis of epilepsy
- ☐ intracranial hemorrhage
- ☐ closed head injury
- ☐ a shunt in your head or neck
- ☐ metal plate in skull
- ☐ Implanted magnetic-sensitive devices (e.g., cochlear implants, pacemakers, aneurysm clips)
- ☐ drug addiction or current drug use

If "other(s)", please specify

_____

5. Answer the following

Do you drink Alcohol dailiy
☐ Yes ☐ No

If yes, how many alcohol drinks a day?

_____

Do you take benzodiazepines (example- xanax, klonopin, ativan) ?
☐ Yes ☐ no

If yes, what do you take and when?

_____

Have you ever been diagnosed with the following?
☐ Bipolar Disorder ☐ Schizophrenia ☐ Psychosis

6. Please note any of the medications you have taken for mental health symptoms:

	Dose?	When started	When stopped	Why discontinued
Prozac (fluoxetine)				
Zoloft (sertraline)				
Lexapro (estalipram)				
Celexa (citalipram)				
Fluvoxamine				
Paxil (paroxetine)				
Pristiq (desvenlafaxine)				
Cymbalta (duloxetine)				
Effexor (venlafaxine)				
Abilify (aripiprazole)				
Rexulti (brexpiprazole)				
Latuda (lurasidone)				
Geodon (ziprasidone)				
Seroquel (quetiapine)				
Trileptal (oxacarbazepine)				
Lamictal (lamotrigine)				
Lithium (eskalith)				
Anafranil (clomipramine)				
Sinequan (doxipin)				
Tofranil (imipramine)				
Wellbutrin (buproprion)				
Trazodone (desyrel)				
Trintellix (vortioxetine)				
xanax (alprazolam)				
ativan (lorazepam)				
klonopin (clonazepam)				
buspar (buspirone)				
amitriptyline				

other:

_____

7. Who is your current mental health care provider and their phone number?

8. CURRENT Psychiatric Medications

	Medication	Dose	Date Started	Response	Who Prescribed
1					

9. Please list other current medications

	Name	Why prescribed	Who prescribed
1			
2			

10. Please list all currently non psychiatric prescribed medications

	Name	Dosage	Why prescribed
1			
2			

11. Please list your allergies (medical or otherwise)

12. Please list all over the counter medications:

	Name	Dosage	How long?
1			
2			

13. Please list any supplements:

	Name of supplement	Dosage	How long?
1			
2			

14. Do you have a Therapist?

Do you have a therapist
☐ Yes ☐ No

If so, who is your therapist?

Therapist contact information?

How often do you see your therapist?

What type of therapy is provided?
☐ Cognitive Behavioral Therapy ☐ EMDR (therapy for traumatic experiences)
☐ Psychodynamic (exploring unconscious thoughts) ☐ Insight oriented ☐ Mindfulness
☐ ERP (Exposure and response prevntion)

if you haven't had therapy, have you had extended appointments (30 min or more) with your mental health medical provider?
☐ Yes ☐ No

If yes, how often?

15. Are you currently Suicidal?

16. Have you ever been hospitalized for mental health reasons?

If so, when?

How long did you stay?

17. Have you had TMS or ECT therapy in the past?

○ yes ○ no

if yes- when and where?

By signing below, I have reviewed the benefits information provided by my provider. I have asked any questions regarding my benefits. I understand that the benefits provided herein are not a guarantee of coverage and I am responsible for any services not covered by insurance.

Signature

Date

Zung Self-Rating Anxiety Scale (SAS)

18. Client Name:

Date of Birth:

19. **Listed below are 20 statements. Please read each one carefully and decide how much the statement describes how you have been feeling during the past week. Select the appropriate number for each statement.**

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1. I feel more nervous and anxious than usual.				
2. I feel afraid for no reason at all.				
3. I get upset easily or feel panicky.				
4. I feel like I'm falling apart and going to pieces.				
6. My arms and legs shake and tremble.				
7. I am bothered by headaches, neck and back pains.				
8. I feel weak and get tired easily.				
10. I can feel my heart beating fast.				
11. I am bothered by dizzy spells.				
12. I have fainting spells or feel faint.				
14. I get feelings of numbness and tingling in my fingers and toes.				
15. I am bothered by stomachaches or indigestion.				
16. I have to empty my bladder often.				
18. My face gets hot and blushes.				
20. I have nightmares.				

20. **Listed below are 20 statements. Please read each one carefully and decide how much the statement describes how you have been feeling during the past week. Select the appropriate number for each statement.**

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
5. I feel that everything is all right and nothing bad will happen.				
9. I feel calm and can sit still easily.				
13. I can breathe in and out easily.				
17. My hands are usually dry and warm.				
19. I fall asleep easily and get a good night's rest.				

Patient Health Questionnaire-9

21. Please enter the client's information:

Client First Name: _____ Client's Last Name: _____ Client DOB: _____

22.

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than one-half the days	Nearly everyday
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Feeling tired or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
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 that usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

By signing below, I declare that I've provided accurate information regarding my current mental health status for which I am seeking TMS treatment.

_____ _____

Signature Date