UNC SCHOOL OF MEDICINE
DEPARTMENT of PSYCHIATRY

THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

DEPARTMENT OF PSYCHIATRY
TMS Clinic
77 Vilcom Center Drive , Suite #300
Chapel Hill, NC 27514

Transcranial Magnetic Stimulation
New Patient Intake Packet

Thank you for your interest in the UNC TMS Clinic! Please review our website to learn more about our clinic and TMS therapy to determine if we are a right fit for your psychiatric needs. Feel free to call our new patient intake coordinators at 984-974-3989 if you have questions about our services or providers and reach out directly to our financial coordinator at 984-974-3931 if you have questions about cost or insurance coverage. We ask that you work with your doctor to complete this packet in-full and mail or fax to our intake coordinators PRIOR to scheduling your TMS consultation appointment. This information will allow us to have a more meaningful conversation in our initial consultation and determine how we may best cater to your specific needs as a potential TMS candidate.

Thank you and we look forward to meeting you soon!

Please Fax or Mail completed packet to:

UNC Psychiatry Outpatient Clinic/ TMS Clinic
77 Vilcom Center Drive
Suite #300
Chapel Hill, North Carolina 27514

Phone: (984)-974-3989
Fax : (984)-974- 9646

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Patient Information		
Last Name:	Middle:	First Name:
Date of Birth:	Phone:	Email:
Gender: ☐ Male ☐ Female ☐ Nonbinary	Preferred Pronouns: ☐He/Him ☐ She/Her ☐They/Them	
Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner		
Race/Ethnicity: ☐Caucasian ☐African American ☐Hispanic ☐Asian ☐Native American ☐Other:		
Address		Apt #
City	State	Zip

Primary Insurance Information	
Insurance Provider:	Insurance Policy Holder:
Insurance Number:	Group Number:
Relationship to Policy Holder:	Policy Holder DOB:

Referring Provider *To be completed by referring provider.*	
Referring Provider Name:	
Office Phone Number:	Office Fax:
Discussed TMS as treatment option with patient: ☐ Yes ☐No	
Referral Diagnosis: ☐F32.2, Major depressive disorder, single episode, severe without psychotic features ☐F33, Recurrent depressive disorder ☐Other:	
Has patient failed at least four (4) full medication trials? ☐ Yes ☐ No	
Has patient engaged in psychotherapy? ☐ No ☐ Yes, if so where/when:	
Any non-removable metal in or around the patient's head? ☐ No ☐ Yes, if so where/what:	
Has the patient had prior ECT? ☐ No ☐ Yes, if so where/when:	
Has the patient had prior TMS? ☐ No ☐ Yes, if so where/when:	
Personal history of seizures? ☐ No ☐ Yes	
Family History of seizures: ☐ No ☐ Yes, if so who:	

SAFETY SCREEN FOR TMS CANDIDATES

Please complete the following information to the best of your knowledge

Question:	***Please check the appropriate box.***	
Do you have epilepsy or have you ever had a convulsion or seizure?	☐ Yes	☐ No
Have you ever had a fainting spell or syncope? If yes, please describe event(s):	☐ Yes	☐ No
Have you ever had a head trauma that was diagnosed as a concussion or was associated with loss of consciousness? If yes, please describe event(s):	☐ Yes	☐ No
Do you have any hearing problems or ringing in your ears?	☐ Yes	☐ No
Do you have cochlear implants?	☐ Yes	☐ No
Are you pregnant or is there a chance that you might be?	☐ Yes	☐ No
Do you have metal in the brain, skull, or elsewhere in your body? (splinters, fragments, clips, etc.) If so, specify location and type of metal:	☐ Yes	☐ No
Do you have an implanted neurostimulator (e.g. DBS, epidural, subdural, VNS)?	☐ Yes	☐ No
Do you have a cardiac pacemaker or intracardiac lines?	☐ Yes	☐ No
Do you have a medication infusion device?	☐ Yes	☐ No
Did you undergo MRI in the past? If so, were there any issues?	☐ Yes	☐ No
Did you undergo TMS in the past? If so, were there any issues?	☐ Yes	☐ No

PSYCHIATRIC AND MEDICAL HISTORY

Please complete the following information to the best of your knowledge so that our clinic staff may best assist with the insurance prior authorization process.

Current Medications *Please list ALL the medications currently prescribed to you by any doctor. Please include any vitamins and/or supplements.*		
Medication Name *Example: Zoloft*	Dosage *Example: 150mg*	Times taken per day *Example: once each morning*

Past Psychiatric Medications			
Medication Name *Example: Zoloft*	Dosage *Example: 150mg*	Length of time taken *Example: 3 months*	Reason for discontinuation *Example: It made me too drowsy*

Allergies *Please list any medication allergies below*	
Medication Name *Example: Penicillin*	Reaction *Example: Hives*
☐ I have no known drug allergies	

Medical History *Please circle any condition below that applies to your personal medical history and briefly explain in space provided.*		
Diabetes	Hypertension	High Cholesterol
Migraines	Chronic Pain	Acid Reflux
Fibromyalgia	IBS	Thyroid Disease
Heart Disease	Head Injury	Cancer
Seizures	Sleep Apnea	Stroke
Anxiety	Depression	ADHD
Alzheimer's	Parkinson's	Alcohol/Drug Abuse
Other:	Other:	Other:
Other:	Other:	Other:

Psychiatric Inpatient Hospitalizations		
Name of Hospital	Dates of Admission	Reason for admission

Current Psychiatric Symptoms *Please check any symptoms below that you have experienced in the past 2 weeks.*		
☐ Low mood	☐ Tearfulness	☐ Hopelessness
☐ Euphoria	☐ Anxiety	☐ Panic attacks
☐ Irritability	☐ Guilt	☐ Loss of interest
☐ Low motivation	☐ Difficulty concentrating	☐ Withdrawn
☐ Insomnia	☐ Fatigue/ Low energy	☐ Nightmares
☐ Auditory hallucinations	☐ Visual hallucinations	☐ Paranoia
☐ Weight changes (gain/loss)	☐ Appetite changes	☐ Obsessive thoughts
☐ Other:	☐ Other:	☐ Other:

Social History
Are you currently Employed? ☐ No ☐ Yes, if so where:
Highest level of education: ☐ some HS ☐ HS/GED ☐ some college ☐ masters ☐ professional
Military Background: ☐ No ☐ Yes, if so what branch/when:
Living situation: ☐ With spouse/partner ☐ with parent(s) ☐ with children ☐ other:
Do you use alcohol? ☐ No ☐ Yes, if so how many drinks per day on average in last month?
Do you use tobacco products? ☐ No ☐ Yes, if so indicate type/amount per week:
Servings of caffeinated drinks (coffee, tea, cola, energy drinks) per day:

Family History												
Place a check to indicate any family members that have or have had any conditions below:	Father	Mother	Sons	Daughters	Brothers	Sisters	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles
Diabetes												
Hypertension												
Heart Disease												
Stroke												
Thyroid Disease												
Dementia												
Seizures												
Kidney Disease												
Cancer												
Alcoholism												
Drug Abuse												
Psychiatric Disorders												
Other:												
Please complete the information below for each family member noted above.												
Living or Deceased (L/D)												
If deceased, age at death												