

## **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 TMS Clinic Coordinator at 984-974-3983 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)-974-3983**

**Fax: (984)-974- 9646**

## Transcranial Magnetic Stimulation New Patient Intake Packet

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

<b>Primary Insurance Information</b>	
Insurance Provider:	Insurance Policy Holder:
Insurance Number:	Group Number:
Relationship to Policy Holder:	Policy Holder DOB:

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

## SAFETY SCREEN FOR TMS CANDIDATES

*Please complete the following information to the best of your knowledge*

<b>Question:</b>	<i>Please check the appropriate box.</i>	
Do you have epilepsy or have you ever had a convulsion or seizure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a fainting spell or syncope? If yes, please describe event(s):	<input type="checkbox"/> Yes	<input type="checkbox"/> 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):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any hearing problems or ringing in your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have cochlear implants?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant or is there a chance that you might be?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have an implanted neurostimulator (e.g. DBS, epidural, subdural, VNS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a cardiac pacemaker or intracardiac lines?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a medication infusion device?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you undergo MRI in the past? If so, were there any issues?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you undergo TMS in the past? If so, were there any issues?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 request process.*

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

<b>Psychiatric Inpatient Hospitalizations</b>		
Name of Hospital	Dates of Admission	Reason for admission

<b>Allergies</b>	
<i>Please list any medication allergies below</i>	
Medication Name <i>Example: Penicillin</i>	Reaction <i>Example: Hives</i>
<input type="checkbox"/> I have no known drug allergies	

### Past Psychiatric Medications

*If you have ever taken any of these medications, please indicate the dates, maximum dosage, response.*

Antidepressants	Dates	Dosage	Response/side effects
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortriptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Pristiq (desvenlafaxine)			
Fetzima (levomilnacipran)			
Viibryd (vilazodone)			
Trintellix (vortioxetine)			

Mood Stabilizers	Dates	Dosage	Response/side effects
Tegretol (carbamazepine)			
Lithobid (lithium)			
Depakote (valproate)			
Lamictal (lamotrigine)			
Trileptal (oxcarbazepine)			
Topamax (topiramate)			
Neurontin (gabapentin)			

Anti-anxiety Meds	Dates	Dosage	Response/side effects
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Atarax/Vistaril (hydroxyzine)			
Buspar (buspirone)			
Catapres (clonidine)			
Minipress (prazosin)			

<b>Antipsychotics</b>	<b>Dates</b>	<b>Dosage</b>	<b>Response/side effects</b>
Haldol (haloperidol)			
Clozaril (clozapine)			
Seroquel (quetiapine)			
Zyprexa (olanzapine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Saphris (asenapine)			
Invega (paliperidone)			
Latuda (lurasidone)			
Rexulti (brexpiprazole)			
Vraylar (cariprazine)			
Fanapt (iloperidone)			

<b>Sedative/Hypnotics</b>	<b>Dates</b>	<b>Dosage</b>	<b>Response/side effects</b>
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Belsomra (suvorexant)			

<b>ADHD Meds</b>	<b>Dates</b>	<b>Dosage</b>	<b>Response/side effects</b>
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Vyvanse (lisdexamfetamine)			
Intuniv (guanfacine)			
Dexedrine (dextroamphetamine)			
Focalin (dexmethylphenidate)			

<b>Other Psych Meds</b>	<b>Dates</b>	<b>Dosage</b>	<b>Response/side effects</b>

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

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

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

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

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Over the last 2 weeks, how often have you been  
bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns

	+		+	
--	---	--	---	--

(Healthcare professional: For interpretation of TOTAL, TOTAL: \_\_\_\_\_  
please refer to accompanying scoring card).

**10.** 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	_____

## PHQ-9 Patient Depression Questionnaire

### For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

### *Consider Major Depressive Disorder*

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

### *Consider Other Depressive Disorder*

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

**Note:** Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

### To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

### Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;  
More than half the days = 2; Nearly every day = 3

### Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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## Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score ( <i>add your column scores</i> ) =				

If you checked off any problems, how difficult have these 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 \_\_\_\_\_

### Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

### Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
  - 0 I do not feel sad.
  - 1 I feel sad
  - 2 I am sad all the time and I can't snap out of it.
  - 3 I am so sad and unhappy that I can't stand it.
2.
  - 0 I am not particularly discouraged about the future.
  - 1 I feel discouraged about the future.
  - 2 I feel I have nothing to look forward to.
  - 3 I feel the future is hopeless and that things cannot improve.
3.
  - 0 I do not feel like a failure.
  - 1 I feel I have failed more than the average person.
  - 2 As I look back on my life, all I can see is a lot of failures.
  - 3 I feel I am a complete failure as a person.
4.
  - 0 I get as much satisfaction out of things as I used to.
  - 1 I don't enjoy things the way I used to.
  - 2 I don't get real satisfaction out of anything anymore.
  - 3 I am dissatisfied or bored with everything.
5.
  - 0 I don't feel particularly guilty
  - 1 I feel guilty a good part of the time.
  - 2 I feel quite guilty most of the time.
  - 3 I feel guilty all of the time.
6.
  - 0 I don't feel I am being punished.
  - 1 I feel I may be punished.
  - 2 I expect to be punished.
  - 3 I feel I am being punished.
7.
  - 0 I don't feel disappointed in myself.
  - 1 I am disappointed in myself.
  - 2 I am disgusted with myself.
  - 3 I hate myself.
8.
  - 0 I don't feel I am any worse than anybody else.
  - 1 I am critical of myself for my weaknesses or mistakes.
  - 2 I blame myself all the time for my faults.
  - 3 I blame myself for everything bad that happens.
9.
  - 0 I don't have any thoughts of killing myself.
  - 1 I have thoughts of killing myself, but I would not carry them out.
  - 2 I would like to kill myself.
  - 3 I would kill myself if I had the chance.
10.
  - 0 I don't cry any more than usual.
  - 1 I cry more now than I used to.
  - 2 I cry all the time now.
  - 3 I used to be able to cry, but now I can't cry even though I want to.

11.  
0 I am no more irritated by things than I ever was.  
1 I am slightly more irritated now than usual.  
2 I am quite annoyed or irritated a good deal of the time.  
3 I feel irritated all the time.
12.  
0 I have not lost interest in other people.  
1 I am less interested in other people than I used to be.  
2 I have lost most of my interest in other people.  
3 I have lost all of my interest in other people.
13.  
0 I make decisions about as well as I ever could.  
1 I put off making decisions more than I used to.  
2 I have greater difficulty in making decisions more than I used to.  
3 I can't make decisions at all anymore.
14.  
0 I don't feel that I look any worse than I used to.  
1 I am worried that I am looking old or unattractive.  
2 I feel there are permanent changes in my appearance that make me look unattractive  
3 I believe that I look ugly.
15.  
0 I can work about as well as before.  
1 It takes an extra effort to get started at doing something.  
2 I have to push myself very hard to do anything.  
3 I can't do any work at all.
16.  
0 I can sleep as well as usual.  
1 I don't sleep as well as I used to.  
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.  
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17.  
0 I don't get more tired than usual.  
1 I get tired more easily than I used to.  
2 I get tired from doing almost anything.  
3 I am too tired to do anything.
18.  
0 My appetite is no worse than usual.  
1 My appetite is not as good as it used to be.  
2 My appetite is much worse now.  
3 I have no appetite at all anymore.
19.  
0 I haven't lost much weight, if any, lately.  
1 I have lost more than five pounds.  
2 I have lost more than ten pounds.  
3 I have lost more than fifteen pounds.

- 20.
- 0 I am no more worried about my health than usual.
  - 1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
  - 2 I am very worried about physical problems and it's hard to think of much else.
  - 3 I am so worried about my physical problems that I cannot think of anything else.
- 21.
- 0 I have not noticed any recent change in my interest in sex.
  - 1 I am less interested in sex than I used to be.
  - 2 I have almost no interest in sex.
  - 3 I have lost interest in sex completely.

## INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score \_\_\_\_\_ Levels of Depression

1-10 _____	These ups and downs are considered normal
11-16 _____	Mild mood disturbance
17-20 _____	Borderline clinical depression
21-30 _____	Moderate depression
31-40 _____	Severe depression
over 40 _____	Extreme depression

[http://www.med.navy.mil/sites/NMCP2/PatientServices/SleepClinicLab/Documents/Beck\\_Depression\\_Inventory.pdf](http://www.med.navy.mil/sites/NMCP2/PatientServices/SleepClinicLab/Documents/Beck_Depression_Inventory.pdf)