CARILION CLINIC

Transcranial Magnetic Stimulation Screening Questionnaire

Before you are able to receive TMS treatment, we need to make sure that it is safe for you to do so. To that end, we need information about the possible factors that could enhance your risk to experience unintentional adverse effects. Please fill out the questionnaire carefully and honestly. This form will subsequently be assessed by a physician.

First and last name:

_____

Please also place your initials at the bottom of each page

Screening questionnaire

1) Do you have epilepsy? ☐ Yes ☐ No
If yes, please specify:

_____

2) Have you ever had a convulsion or a seizure? ☐ Yes ☐ No
If yes, please specify:

_____

3) Does someone in your family have epilepsy? ☐ Yes ☐ No
If yes, how are you related to this person?

_____

4) Have you ever lost consciousness without any known reason? ☐ Yes ☐ No
If yes, please describe when and how this occurred:

_____

5) Have you ever had a severe head trauma? ☐ Yes ☐ No
If yes, please specify:

_____

6) Have you ever had a stroke? ☐ Yes ☐ No
If yes, please specify:

_____

7) Have you ever undergone surgery to your head? ☐ Yes ☐ No
If yes, please specify:

_____

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8) Do you have any of the following implants in your body?

☐ (metal) Plates and/or screws	☐ Yes	☐ No
☐ Vascular clips	☐ Yes	☐ No
☐ Artificial heart valve	☐ Yes	☐ No
☐ Metallic splinters/shrapnel/etc.	☐ Yes	☐ No
☐ Pacemaker	☐ Yes	☐ No
☐ Insulin pump	☐ Yes	☐ No
☐ Internal hearing aid (cochlear implant)	☐ Yes	☐ No
☐ Any other implant not mentioned above	☐ Yes	☐ No

If you answered "yes" to any of the questions above, please specify:

_____

9) Do you have any deviations of the spinal cord, bone marrow, or the ventricular system (spaces in the brain filled with liquid)? ☐ Yes ☐ No
If yes, please specify:

_____

10) Do you have any hearing disabilities or ringing in your ears? ☐ Yes ☐ No
If yes, please specify:

_____

11) Have you ever (at present or in the past) suffered from a brain-related, neurological illness? ☐ Yes ☐ No
If yes, please specify:

_____

12) Do you suffer from frequent severe headaches? ☐ Yes ☐ No
If yes, please describe how often, and on which occasions:

_____

13) Are you currently under any form of medical treatment? ☐ Yes ☐ No
If yes, please specify:

_____

14) Are you currently taking antibiotics (a medication that helps alleviate bacterial infections)? ☐ Yes ☐ No

_____

15) Do you ever take antihistamines (anti-allergy medication)? ☐ Yes ☐ No
If yes, how often and when was the last time you took them?

_____

16) Are you taking any other medications not mentioned above? ☐ Yes ☐ No
If yes, please list:

_____

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17) Do you have a chronic illness/disorder? ☐ Yes ☐ No
If yes, please specify:

_____

18) Have you ever (at present or in the past) had a psychiatric-based illness/disorder? ☐ Yes ☐ No
If yes, please specify:

_____

19) Does someone in your family have a psychiatric-based illness/disorder? ☐ Yes ☐ No
If yes, please specify:

_____

How are you related to this person?

_____

20) Have you used any recreational drugs during the past year (such as marijuana, ecstasy, cocaine, etc.)? ☐ Yes ☐ No
If yes, please specify which drugs did you use, and when was the last time that you used them?

_____

21) Have you ever suffered from substance dependence or abuse? ☐ Yes ☐ No
If yes, please specify:

_____

22) Do you averagely consume more than 3 alcoholic units a day? ☐ Yes ☐ No

_____

23) Do you have sleeping problems? ☐ Yes ☐ No
If yes, please specify:

_____

24) Are you pregnant, or is there a chance that you might be? ☐ Yes ☐ No

_____

25) Have you ever undergone an MRI for clinical purposes? ☐ Yes ☐ No
If yes, did any problems occur during scanning? ☐ Yes ☐ No
If yes, please specify:

_____

26) Have you ever undergone TMS? ☐ Yes ☐ No
If yes, have you ever had an adverse reaction to TMS? ☐ Yes ☐ No
If yes, please specify:

_____

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I answered all questions to the best of my knowledge and belief:

Signature: _____ Date: ____-____-____

Review of Past Treatments

Unable to function at home ☐ Unable to function at work ☐

Evidence of at least four Medications Trials from earliest to latest, including two different agent classes, during this episode.

Medication Class	Med Name	Max Dose	Time Period	Response	Side Effects	Current Med
SSRIs						
SNRIs						
NDRIs						
TCAs						
MAOIs						
Other						

List any augmentation strategies tried in the table below:

Strategy	Max Dose	Response	Side Effects	Notes
Lithium				
Thyroid Hormone				
Stimulants				
Dual Anti-Depressants				
Psychotherapy				
ECT				
Ketamine				

Level of Care	Number of Admission/Sessions	Date/s	Response
Inpatient			
Residential			
Partial/Day Treatment			
Intensive Outpatient Treatment			
Outpatient Therapy			

Other Therapies? (Describe date of treatment and effectiveness): _____

_____

_____

_____

_____

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