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Uptown Psych

WELCOME TO UPTOWN PSYCH TMS

HISTORY

TMS has been approved by the FDA for the treatment of depression since October 2008. The interest in magnetic fields started in the mid 1980's for evidence began showing they possessed potential therapeutic value.

The first controlled trials in North America started in 1999 and since then many subsequent trials and clinical experiences have further elucidated the therapeutic value of using Transcranial Magnetic Stimulation as a tool in the treatment of depression.

In December 2010 the American Psychiatric Association guidelines in the treatment of depression were modified to include TMS as an appropriate treatment to consider after failing at least one adequate trial of antidepressants.

HOW DOES IT WORK?

The science behind the treatment is based on creating an electromagnetic field based on magnetic resonance imaging technology (MRI). The magnet is applied to the left side of the brain in the dorsolateral prefrontal cortex (DLPFC), without surgery, anesthesia or sedation. The electromagnetic field penetrates 2 to 3 cm into the brain tissue and affects neurons and synapses in an area that is thought to control mood and anxiety pathways. This effect is both directly and indirectly through additional neuronal connectivity with deeper structures. Metabolic scans show that even though the treatment application is localized, the improvement of neuronal functioning is beyond that area due to connections within the brain including both sides of the brain.

TREATMENT COURSE

The FDA recommended treatment for depression is 20-30 sessions usually performed (5-6 days a week), until a full remission (full improvement) is reached. It is a noninvasive outpatient procedure which is usually 37 minutes and 30 seconds that is pre-scheduled with no restriction on activities including driving before and after the treatment.

The first session usually lasts anywhere between one and a half to two hours as we do localization and the first treatment session.

Localization is done in one of two ways:

1. Either by finding the motor threshold in the area of your brain for the right-hand (specifically right thumb) and mapping the treatment sites to be approximately 5.5 cm in front of that area.
2. At other times we achieve the mapping by localizing depending on measurements done on your scalp.

____ Initial here

DAY OF THE TREATMENT

- You can perform your normal daily activities prior and subsequent to the treatment with no restriction of eating, drinking or driving.
- If you are on regular medications make sure you keep the same schedule whether they are psychiatric or non-psychiatric medications.

- If you take medications as needed for anxiety or pain make sure you mention it to the doctor prior to treatment, and normally there is no restriction associated with that.
- Less than 5% have some discomfort or pain especially with the initial treatment, most of the time it is very mild and gets better very quickly, however if you want to take an over-the-counter pain medication before the treatment you may do so at least 30 minutes before the session if you wish.
- During the treatment you will be awake and alert. Patients look forward to listening to music or watching on their mobile device of their choice. Please let our staff know what you might be interested in, so we will make it available if possible.
- During the treatment, the technician will offer you protective earplugs to wear during the treatment.
- Please dress comfortably and casually for your treatment.
- If you have any discomfort, please mention it to the staff person with you.
- If you wish to have a family member or a friend sit with you during the treatment you are welcome to invite them. We have a special chair reserved for them.
- You will be fully awake and alert through the treatment and can always communicate with the staff in the room with you.

FINANCES

As this is a new treatment, your insurance might not automatically pay, however our staff will assist you with any paperwork, billing, our appeals that might be necessary to maximize the probability of getting reimbursed by your insurance (except for Medicare which we have opted out, which means both parties are not eligible to bill Medicare for the treatments).

We do expect payment at time of service, however there are some discounts available based on a set pre payment schedule, please ask our office manager at the time of your visit.

Throughout your treatment our team, including our medical and nursing staff, will be supervising your treatment for maximum efficacy and safety. That supervision and quality of care is included in the fee you have paid for the TMS treatment. Our model of integrated care and teamwork has distinguished our center from many others based on the quality of outcomes. (Please review our website for a summary of our outcomes). We are proud to inform you that we have been selected as an “International Center of Excellence" and are regarded as a model by which to train other centers around the country.

Please note that any additional office consultations during your treatment with Dr Ogundipe or any other clinicians are usually charged based on the normal fee schedule for office visits and that will be separate from the fees collected for your TMS treatment.

____ Initial here

CANCELLATION POLICY

We value and respect your time as we reserve the appointment for you, if you have to cancel or change the appointment please give our staff 48 hours notice so that we will make the proper readjustments in the schedule. If you fail to observe the cancellation policy there will be a charge made for the appointment reserved. We will do our best to try to accommodate rescheduling you with short notice if necessary. That cancellation fee would need to be paid before your next treatment.

____ Initial here

CLINICAL TEAM FOR TMS

At Uptown Psych TMS we take great pride in the integrated approach we have among our staff including clinical and administrative team. Our staff includes a team of providers such as doctors, nursing staff, mid-level providers, psychology and counseling staff, and TMS technical operator's. We will do everything possible to ensure your privacy, comfort, and most importantly your safety and wellness.

Thank you for the confidence you have in us. We always welcome your questions and feedback.

UPTOWN PSYCH TMS OFFICE POLICIES & PROCEDURES

We would like to welcome you to our practice. We strive to provide a full range of clinical behavioral services to individuals, couples, families, and groups in all age ranges. Based on an in-depth evaluation, our clinical philosophy is to utilize an integrated treatment plan including available medical, psychological, interpersonal, behavioral, and psychosocial approaches to dealing with the whole individual. Our staff and associates communicate closely with each other as a team to optimize your wellbeing in a cost-effective manner.

_____ **Confidentiality**. We recognize and appreciate the confidence you place in us. We have the highest respect for your privacy. Except for a few urgent conditions as listed below, no information will be communicated to anyone without your knowledge or consent. The exceptions include:

- Intent to harm oneself.
- Intent to harm another person.
- Child abuse — physical and/or sexual
- Abuse of an elder or dependent adult
- Domestic violence

_____ **Office Hours**. Uptown Psych TMS hours of operation differ due to our flexibility; we are usually available from 9am to 5pm, Monday to Friday, please call our office to verify. Our telephones are answered by our support staff between the hours of 8:00 am and 8:00 pm Monday through Thursday, 8:00 am and 6:00 pm on Fridays, and 8:00 am and 5:00 pm on Saturdays. If you have a medical emergency please call 911, we also have an answering service available that will respond to emergency phone calls that will attempt to reach the doctor on call to meet your emergency needs.

_____ **Financial Policy**. At this point, as TMS is a new treatment, more insurance companies are beginning to cover treatment. Our office is contracted with specific insurances but will additionally work to set up single case agreements with whichever insurances we are not contracted. If insurances authorize treatment, it is the patient’s responsibility to pay the appropriate co-payments at the time of service. We will do our best to have your insurance authorize treatment but, if your insurance denies, we offer you the additional option of paying privately.

_____ **Payment**. Our payment policy at Uptown Psych TMS is like other practices, payments are due at the time of service. Prepaying may entitle you to incentives depending on the prepaid agreement arranged with the office. Please note that if you have prepaid and did not utilize the number of visits which were prepaid, you will be refunded the remaining balance.

_____ **Appointments**. Please make every effort to keep your scheduled appointments. Our cancellation policy requires 48-hours notice in order to avoid being charged for the "missed" appointment. We reserve the appointment for you and often have a list of patients who need to be seen and who could fill your appointment slot should we have adequate time to notify them. Please give us that time.

Canceled appointments require 48-hours notice; otherwise, they will be billed to you and are not reimbursable by your insurance company.

We strive to provide excellent care for you. If you have any feedback or comments to improve our services, please let any of our staff know. Thank you for taking the time to complete this form.
I have read the above and agree to abide by these policies.

PATIENT REGISTRATION

(Please fill in completely. Where not applicable, write N/A)

PATIENT INFORMATION

NAME: _____ DATE: _____
ADDRESS: _____ E-MAIL: _____
CITY: _____ ZIP CODE: _____ SSN: _____
PHONE NUMBER: _____ DATE OF BIRTH: _____
SEX: ☐MALE ☐FEMALE MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widow
EMPLOYER: _____ POSITION: _____
WORK ADDRESS: _____ WORK PHONE: _____
SPOUSE NAME: _____ HOME PHONE: _____
EMPLOYER: _____ POSITION: _____
WORK ADDRESS: _____ WORK PHONE: _____

IF PATIENT IS A MINOR

PARENT/GUARDIAN'S NAME: _____ RELATIONSHIP: _____
DATE OF BIRTH: _____ : SEX: ☐MALE ☐FEMALE SSN: _____
ADDRESS (if different from above): _____
CITY & STATE: _____ ZIP: _____
HOME PHONE (if different from above): _____ WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____
ADDRESS: _____
CITY: _____ ZIP CODE: _____ GROUP/POLICY NUMBER: _____
PHONE NUMBER: _____ FAX NUMBER: _____
NAME OF INSURED: _____ DATE OF BIRTH: _____

REFERRAL INFORMATION

REFERRED BY: _____
CONTACT INFO:_____
PRIMARY PHYSICIAN (if different from above): _____

EMERGENCY INFORMATION

Emergency Contact: _____
Phone number: _____ Relationship: _____

I AUTHORIZE UPTOWN PSYCH. TO EXCHANGE MEDICAL (PSYCHIATRIC) INFORMATION CONCERNING MY EVALUATION AND/OR TREATMENT WITH THE PROFESSIONAL REFERRAL SOURCE NOTED ABOVE AND IF MORE RECORDS ARE NEEDED, A SEPARATE RELEASE WILL BE COMPLETED FOR THAT PURPOSE.

SIGNED: _____ **DATE**: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Privacy Officers: Eva Tokat, Office Manager

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy will be posted in the reception area, and a copy of any amended Notice of Privacy Practices will be available at each appointment. I understand that I have the right to restrict how Dr Ogundipe & Associates uses or disclose my protected health information to carry out treatment, payment and health care operations; that Dr Ogundipe & Associates is not required to agree to the restrictions and; that Dr Ogundipe & Associates bound by restrictions to which it agrees.

I request the following restrictions to how my health information is used or disclosed:

_____

_____

_____

_____

_____

_____

_____

_____

_____

I have the right to revoke this consent by notifying Dr Ogundipe & Associates in writing, except to the extent that Dr Ogundipe & Associates has taken action in reliance on my consent.

_____ _____

Signature Date

_____ _____

Print Name Telephone

If not signed by the patient, please indicate relationship:

☐Parent or guardian of minor patient

☐Guardian or conservator of a patient who is an adult but unable to sign

Name and Address of Patient: _____

_____

_____

CONSENT FOR TREATMENT

I hereby give my consent for any diagnostic or therapeutic services Dr Ogundipe & Associates, including diagnostic evaluation, examination, consulting, psychotherapy and other therapies as appropriate.

I understand that communication between me and my mental health professional* is confidential and privileged to the full extent of the applicable laws. Under these laws, the mental health professional* may disclose information about me to the staff of Uptown Psych, in the provision of therapy or appropriate referrals, and not otherwise without my written permission.

I further understand that certain circumstances are exceptions to the laws of confidentiality, under which a mental health professional* is legally required to report.

These include:

1. Intent to harm myself (suicide)
2. Intent to harm another person
3. Child abuse, physical and /or sexual
4. Abuse of an elder or dependent adult
5. Domestic violence

If a mental health professional* reasonably believes that one of the exceptions apply, he or she will make every effort to resolve the issue by discussing it with me before reporting to the proper agency.

I understand that in group therapy, there is a risk of disclosure of my confidential information by other group members and I will not hold the mental health professional* liable for any breach of confidentiality by other group members.

_____ _____

Date Signature

_____

If not the patient, please print your name and relationship to the patient

**The term "mental health professional" includes any physician, therapist, counselor, nurse or technician that I may come in contact with in treatment at Uptown Psych.*

Credit Card Authorization Form

I, _____, hereby authorize Uptown Psych, to charge my credit card for the amounts invoiced.

Patient's Name: _____

Name on card: _____
(If different from patient's Name)

Type of Card: AMERICAN EXPRESS / DISCOVER / VISA / MasterCard / OTHER
If other, please specify:

Credit Card Number: _____
Expiration Date: _____
CVC Code: _____

Credit Card Billing Address
Street: _____
City: _____ State: _____
Zip Code: _____
Telephone: _____
Email (optional): _____

As the credit card holder, I also authorize Uptown Psych. to charge my credit card for future services and also for late cancellations or failed appointments.

Your completion of this authorization form helps us to protect you, our valued patients, from credit card fraud. Uptown Psych will keep all information entered on this form strictly confidential.

_____ _____
Cardholder's Signature Date

Patient Report

The information requested on this form will be used to assist the staff in evaluating your health status and treatment needs. It will not be used for any other purpose. (A) General Information

NAME: DATE:

_____ _____

(B) Please describe the problems/needs that you would like help for:

_____

_____

_____

_____

_____

_____

(C) Previous medical and/or emotional treatment you have received (include dates, hospitalizations, and surgeries)

_____

_____

_____

_____

_____

_____

(D) List names and addresses of physicians or therapists you have seen in the past few years:

(a) Primary:

_____

(b) Other(s):

_____

(c) Last date of last physical exam:

_____

(E) Medications Currently Used:

Drug Name	Strength (mg)	Frequency

Do you have any medication allergies? ☐ Yes ☐ No (If yes, please specify on the space provided below)

_____

_____

(F) Personal habits (indicate frequency and quantity per daily use):

☐ Alcohol _____

☐ Tobacco _____

☐ Recreational Drugs _____

☐ Caffeine _____

(G) Social History:

(a) Highest level of education:

_____

(b) School presently attending at *(if appropriate)*:

_____

(c) Occupation:

_____

(d) Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

(H) Family History:

	Age	Occupation	Health/Status Problem
Spouse			
Father			
Mother			

Siblings			
Children			

(I) Family Psychiatric History (if applicable, indicate family member):

(a) Mental or emotional problems:

_____

_____

_____

(b) Alcohol/Drug Use:

_____

_____

_____

(J) Are you experiencing problems in any of the following areas? *(If so, please specify)*

(a) Work:

_____

_____

_____

(b) Finances:

_____

_____

_____

(c) Health (include allergies):

_____

_____

_____

(d) Family:

_____

_____

_____

(e) School:

_____

_____

_____

(f) Living Arrangements:

_____

_____

_____

(g) Legal:

_____

_____

_____

Symptom Checklist

Please check any symptoms you have recently experienced:

☐Headaches
☐Dizziness
☐Unexplained pain
☐Menstrual problems/changes
☐Urinary problems
☐Changes in bowel habits (specify)
_____
☐Diarrhea
☐Chronic constipation
☐Other physical symptoms (specify)
_____
☐Heart pounding/racing
☐Feelings of panic
☐Difficulty relaxing ☐Change in appetite
☐Vomiting
☐Nausea
☐Weight gain
☐Feeling hopeless
☐Feeling helpless
☐Mood changes (specify)
_____
☐Changes in memory (specify)
_____
☐Tremors
☐Changes in walk
☐Changes in speech
☐Changes in writing
☐Changes in driving
☐Increased suspicions/concerns
☐Nightmares
☐Hallucinations
☐Excessive/unusual fears
☐Hearing voices
☐Repetitive/bothersome thoughts (specify)
_____
☐Weight loss
☐Fatigue/low energy
☐Early morning awakening
☐Loss of/decreased enjoyment, in pleasure events
☐Changes in energy level
☐Decreased effectiveness at home, work, school
☐Needing to be with others excessively
☐Needing to be alone excessively
☐Excessive, constant guilt
☐Crying spells
☐Thoughts/attempts to hurt self
☐Thoughts of death
☐Thoughts of suicide
☐Thoughts of hurting others
☐Difficulty concentrating
☐Difficulty making decisions
☐Feelings of inadequacy
☐Low self-esteem
☐Feeling slowed down
☐Feeling restless at times

☐Recurrent/bothersome behaviors
☐Feelings of unreality
☐Unusual behaviors (specify)
_____
☐Impulsive Behavior (Problems related to gambling, drinking, eating, spending money, others)
☐Irritability/excessive anger
☐Sexual problems (Describe)
_____
☐Difficulty in relationship
☐Difficulty with mate
☐Difficulty with children
☐Difficulty with co-workers
☐Recommendation of family, friends, associates, to seek help
COMMENTS: _____
_____

_____ _____

_____

Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

General

☐Being overweight
☐Recent weight gain or weight loss
☐Poor appetite
☐Increased appetite
☐Abnormal sensitivity to cold
☐Cold sweats during the day
☐Tired or worn out ☐Hot or cold spells
☐Abnormal sensitivity to heat
☐Excessive sleeping ☐Difficulty sleeping
☐Lowered resistance to infection
☐Flu-like or vague sick feeling
☐Sweating excessively at night
☐Urinating excessively
☐Excessive daytime sweating
☐Excessive thirst

Head, Eye, Ear, Nose, & Throat

☐Facial pain
☐Headache
☐Head injury
☐Neck pain or stiffness
☐Frequent sore throat
☐Blurred vision
☐Double vision
☐Overly sensitive to light
☐See spots or shadows
☐Hearing loss in both ears
☐Ear ringing
☐Disturbances in smell
☐Runny nose
☐Dry mouth
☐Sore tongue ☐Other
_____

Gastrointestinal and Hepatic

Genitourinary

☐Itchy privates or genitals
☐Painful urination
☐Excessive urination
☐Difficulty in starting urine
☐Accidental wetting of self
☐Pus or blood in urine
☐Decreased sexual desire
☐Other
_____

Females

☐No menses
☐Menstrual irregularity
☐Painful or heavy periods
☐Premenstrual moodiness, irritability, anger, tension. bloating, breast tenderness, cramps, headache
☐Painful menstrual periods
☐Painful intercourse or sex
☐Other _____

Neurological

☐Pacing due to muscle restlessness
☐Forgotten periods of time
☐Dizziness
☐Drowsiness
☐Muscle spasms or tremors
☐Impaired ability to remember
☐"Tics"
☐Numbness
☐Convulsions / fits
☐Slurred speech
☐Speech problem (other)
☐Weakness in muscles ☐Other
_____

Respiratory

☐Asthma, wheezing
☐Cough
☐Coughing up blood or sputum
☐Shortness of breath
☐Rapid breathing
☐Repeated nose or chest colds
☐Other _____

Chest and Cardiovascular

☐Ankle swelling
☐Rapid / irregular pulse
☐Breast tenderness
☐Chest pain
☐High blood pressure
☐Low blood pressure
☐Other
☐Trouble swallowing
☐Nausea or vomiting (throwing up)
☐Abdominal (stomach / belly) pain
☐Anal itching
☐Painful bowel movements
☐Infrequent bowel movements
☐Liquid bowel movements
☐Loss of bowel control
☐Frequent belching or gas
☐Vomiting blood
☐Rectal bleeding (red or black blood)
☐Jaundice (yellowing of skin) ☐Other
_____

Musculoskeletal

☐Back pain or stiffness ☐Bone pain
☐Joint pain or stiffness
☐Leg pain
☐Muscle cramps or pain ☐Other
_____

Skin, Hair

☐Dry hair or skin
☐Itchy skin or scalp
☐Easy bruising
☐Hair loss
☐Increased perspiration
☐Sun sensitivity
☐Other _____
☐Sterility infertility
☐Abnormal vaginal discharge ☐Other
_____

Males

☐Impotence (weak male erection)

☐Inability to ejaculate or orgasm
☐Scrotal pain
☐Abnormal penis discharge
☐Other
_____

Explanation
_____
_____

BURN'S ANXIETY INVENTORY

Instructions: Circle the answer that best describes how much that symptom or problem has bothered you during the past seven (7) days.

Category I Anxious Feelings				
1.Anxiety, nervousness, worry, or fear	0	1	2	3
2. Feeling that things around you are strange, unreal, or foggy	0	1	2	3
3. Feeling detached from all or part of your body	0	1	2	3
4. Sudden, unexpected panic spells	0	1	2	3
5. Apprehension or a sense of impending doom	0	1	2	3
6. Feeling tense, stressed, uptight or on edge	0	1	2	3
Category II Anxious Thoughts				
7. Difficulty concentrating	0	1	2	3
8. Racing thoughts or having your mind jump from one thing to next	0	1	2	3
9. Frightening fantasies or daydreams	0	1	2	3
10. Feeling that you're on the verge of losing control	0	1	2	3
11. Fears of cracking up or going crazy	0	1	2	3
12. Fears of fainting or passing out	0	1	2	3
13. Fears of physical illness or heart attacks or dying	0	1	2	3
14. Concerns about looking foolish or inadequate in front of others	0	1	2	3
15. Fears of being alone, isolated or abandoned	0	1	2	3
16. Fears of criticism or disapproval	0	1	2	3
17. Fears that something terrible is about to happen	0	1	2	3
Category III: Physical Symptoms				
18. Skipping or racing or pounding of the heart	0	1	2	3
19. Pain, pressure or tightness in the chest	0	1	2	3
20. Tingling or numbness in the toes or fingers	0	1	2	3
21. Butterflies or discomfort in the stomach	0	1	2	3
22. Constipation or diarrhea	0	1	2	3
23. Restlessness or jumpiness	0	1	2	3
24. Tight, tense muscles	0	1	2	3
25. Sweating not brought on by heat	0	1	2	3
26. A lump in the throat	0	1	2	3
27. Trembling or shaking	0	1	2	3
28. Rubbery or "jelly" legs	0	1	2	3
29. Feeling dizzy, light-headed or off balance	0	1	2	3

30. Choking or smothering sensations or difficulty breathing	0	1	2	3
31. Headaches or pains in the neck or back	0	1	2	3
32. Hot flashes or cold chills	0	1	2	3
33. Feeling tired, weak or easily exhausted	0	1	2	3
Add Column:				

Name_____Date_____Total_____

THE BURNS DEPRESSION INVENTORY

NAME: _____ DATE: _____

INSTRUCTIONS: The following is a list of symptoms that people sometimes have. Put a check ( ) in the space to the right that bests describes how much that symptom or problem has bothered you during this past week.	0 – NOT AT ALL	1- SOMEWHAT	2- MODERATELY	3- A LOT
SYMPTOM LIST				
Sadness: Do you feel sad or down in the dumps?	0	1	2	3
Discouragement: Does your future look hopeless?	0	1	2	3
Low Self-Esteem: Do you feel worthless?	0	1	2	3
Inferiority: Do you feel inadequate or inferior to others?	0	1	2	3
Guilt: Do you get self-critical and blame yourself?	0	1	2	3
Indecisiveness: Is it hard to make decisions?	0	1	2	3
Irritability: Do you frequently feel angry or resentful?	0	1	2	3
Loss of interest in life: Have you lost interest in your career, hobbies, family and friends?	0	1	2	3
Loss of motivation: Do you have to push yourself to do things?	0	1	2	3
Poor Self-Image: Do you feel old and unattractive	0	1	2	3
Appetite Changes: Have you lost your appetite? Do you overeat or binge compulsively?	0	1	2	3
Sleep Changes: Is it hard to get at good night's sleep? Are you excessively tired and sleeping too much?	0	1	2	3
Loss of Libido: Have you lost your interest in sex?	0	1	2	3
Concerns about Health: Do you worry excessively about your health?	0	1	2	3
Suicidal Impulses? Do you have thoughts that life is not worth living or think you'd be better off dead?	0	1	2	3
	0			

Add up your total and record it here:
Total: ____

The Feeling Good Handbook, *David Burns, M.D., Penguin Group, 1999.*

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

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*
1. Little interest or pleasure in doing things.	○	○	○	○
2. Feeling down, depressed, or hopeless.	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much.	○	○	○	○
4. Feeling tired or having little energy.	○	○	○	○
5. Poor appetite or overeating.	○	○	○	○
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television.	○	○	○	○
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.	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself.	○	○	○	○
Add columns:		+	+	
			Total:	

10. If you checked off any problems, how difficult at all 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

GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*

	Not at all	**Several days**	**More than half the days**	**Nearly Every day**
1. Feeling nervous, anxious or on edge	◯	◯	◯	◯
2. Not being able to stop or control worrying	◯	◯	◯	◯
3. Worrying too much about different things	◯	◯	◯	◯
4. Trouble relaxing	◯	◯	◯	◯
5. Being so restless that it is hard to sit still	◯	◯	◯	◯
6. Becoming easily annoyed or irritable	◯	◯	◯	◯
7. Feeling afraid as if something awful might happen	◯	◯	◯	◯
Add score for each column				
Total				

If you checked off any problems, how difficult at all 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

The GAD-7 originates from Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. GAD-7 © Pfizer Inc. all rights reserved

Prior Treatment History

We are happy to provide the consultation for you and to discuss available treatment options for your condition.

In order for us to have the most productive consultation and recommendations we would very much welcome any and all information you can provide about your condition at the time of the consultation if at all possible. You might not remember all the details however sometimes consulting others who are familiar with your condition (family members or friends), your prior records as well as pharmacy refill records can help complete the list.

Please take a few minutes to complete the following prior treatment questionnaire. Check the medications you have tried, and in the comments include dosage and approximate length of treatment and outcome.

A. MEDICATION TREATMENT:

Filling up the necessary information increases the chance of timely insurance processing and/or reimbursement.

Medication Class and Examples	**Dosage**	**Date Range (at least year to year range)**	**Reason why medication was stopped.**

1. *SSRIs (Selective Serotonin Reuptake Inhibitors):* __Prozac(Fluoxetine) __Zoloft(Sertraline) __Paxil(Paroxetine) __Celexa(Citalopram) __Lexapro(Escitalopram) __Luvox(Fluvoxamine)	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____
2. *SNRIs (Selective Serotonin & Norepinephrine Reuptake Inhibitors):*			

__Effexor(Venlafaxine) __ Pristiq (Desvenlafaxine) __Cymbalta(Duloxetine)	_____ _____ _____	_____ _____ _____	_____ _____ _____
3. Atypical Antidepressants: __Wellbutrin(Buproprion) __Remeron(Mirtazepine) __Serzone(Nefazadone) __Trazodone(Desyrel) __Vibryd __Trintellix __Fetzima	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____

4.*Tricyclic Antidepressants:* __Elavil(Amitriptyline) __Tofranil(Imipramine) __Pamelor(Nortriptyline) __Norpramin(Desipramine) __Aventyl(Protriptyline) __Asendin(Amoxapine) __Ludiomil(Maprotyline) Other_____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
5. *Monoamine Oxidase Inhibitors (MAOIs):* __Nardil(Phenelzine) __Parnate __Emsam patches	_____ _____ _____	_____ _____ _____	_____ _____ _____
6. *Neuroleptics(SCA):*			
__Abilify(Aripiprazole) __Seroquel(Quetiapine) __Risperdal(Risperidone) __Zyprexa(Olanzepine) __Geodon(Ziprazidone) __Saphris __Latuda __Invega Other_____	_____ _____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____ _____

7. *Mood Stabilizers:* __Lithium __Depakote __Tegretol __Trileptal __Lamictal(Lamotrigine) Other_____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____
8. *Augmentation* __Thyroid supplements (Synthroid, Levoxyl, Cytomel, Armourthyroid,etc.) __Psychostimulants (Ritalin, Adderral, Dexedrine, Vyvanse,Provigil, Nuvigil) __Buspar (Buspirone) __Deplin(L-Methylfolate), Other_____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____

B.PSYCHOTHERAPY:

__Supportive __Cognitive Behavioral (CBT) __DBT __EMDR Other (please specify): _____	_____ _____ _____ _____ _____ _____

C. Electro Cortical Therapy (ECT, Shock therapy):

Comments_____

_____

D. Prior Transcranial Magnetic Stimulation (TMS):
Comments_____
_____

E. Psychiatric admissions or Partial Hospital Treatment:
Comments_____
_____