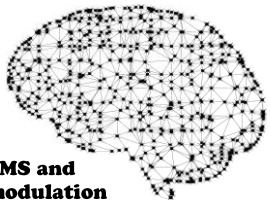


UCSF TMS and Neuromodulation Service

TMS Program Evaluation
Pre-Visit Patient Information

MRN: _____

Patient Name: _____

Date of Service: _____

CARE PROVIDERS:

PATIENT INFORMATION:

WORK HISTORY:

FAMILY/EARLY ENVIRONMENT:

Where were you born?_____

Health issues or complications during your mother's pregnancy, labor/delivery, or during your infancy?_____

Who raised you during your childhood?_____

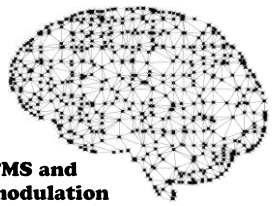
Number of siblings:____ Your place in birth order:_____

Family members with psychiatric disorders or substance abuse?

_____

0 - 5 RATING SCALE (0=not at all. ..... 5=extremely)

How stressful was your early life (birth - 5 years)?	0	1	2	3	4	5
How stressful was your childhood (age 6 - 12 years)?	0	1	2	3	4	5
How stressful were your teen years (age 13 - 19 years)?	0	1	2	3	4	5



UCSF TMS and Neuromodulation Service

TMS Program Evaluation
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MRN: _____

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Date of Service: _____

YOUR EXPERIENCE WITH DEPRESSION:

BASELINE:

What were you like before depression? Describe your personality as you are/were in your healthiest times of life:

_____

_____

_____

What hobbies or leisure activities did/do you enjoy when you were/are NOT depressed?

_____

_____

_____

ONSET/TREATMENT/COURSE:

How old were you when you first experienced symptoms? ____

Describe the symptoms _____

When did you first get treatment? (age or year) _____

Describe first treatment (age or year; medication or therapy) _____

_____

_____

Which one best describes your LIFETIME experience with depression:

☐ "Episodes" of more severe symptoms (at least 2 weeks) with some periods between episodes when I feel better/relatively normal

☐ Chronic symptoms that never get more than 50% better

☐ Both - I have episodes with a clear start and finish, but I'm not fully well in between

When did this current episode of depression begin? ____

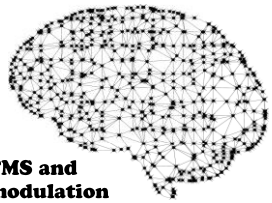
List any activities of your daily life that you are not currently able to perform fully because of your depression: _____

_____

_____

0 - 5 RATING SCALE (0=not at all. ..... 5=extremely)

How closely have you followed your doctor's recommendations about treatment? 0 1 2 3 4



UCSF TMS and Neuromodulation Service

TMS Program Evaluation
Pre-Visit Patient Information

MRN: _____

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PSYCHIATRIC CARE HISTORY - OVERVIEW:

Are you currently undergoing counseling and/or therapy? (i.e. CBT, neurofeedback, meditation, etc.)

☐ no ☐ yes: ____ What kind? _____

How often? _____

For how long? _____

Please provide as much detail as you can on treatments you've received in the past:
(dates, names, focus of care)

☐ Outpatient Psychotherapy_____

☐ Outpatient Psychiatric Medication Management_____

☐ Day Hospital (Intensive Outpatient) Programs_____

☐ Hospital Admission for Psychiatric Care (Hospital names/Dates):

_____

_____

☐ Hospital admission for drug/alcohol detox_____

☐ Drug/Alcohol Rehab programs_____

_____

☐ ECT (electroconvulsive therapy)? _____

☐ Research/investigational Treatments? _____

Have you ever made a suicide attempt or harmed yourself physically when you were feeling you might not want to keep living with your depression? Describe:

_____

_____

Even if no treatment has ever fully resolved your depression, which treatment has worked best for relieving your symptoms?

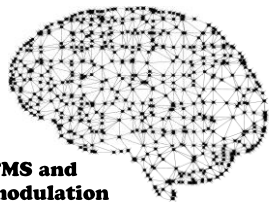
_____

_____

Have you ever experienced full recovery (all the way better for at least a year) from an episode of depression? If yes, describe:

_____

_____



UCSF TMS and Neuromodulation Service

TMS Program Evaluation
Pre-Visit Patient Information

MRN: _____

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Describe any bad reaction you've had to a medicine for depression:

_____

_____

☐ **Please provide a list of all the psychiatric medications you have taken in the past for your depression. You may need to request copies of records from your pharmacy, outpatient doctor, or hospital.**

What is your understanding of your mental health diagnosis?

☐Unipolar Depression

☐ Bipolar Disorder - Depression alternating with manic or hypomanic states

☐ Some other diagnosis is the reason I'm here:_____

Do you have other psychiatric disorders in addition to depression?

☐ no ☐ yes:_____

Did/do you have a substance abuse disorder?

☐ no ☐ yes:_____

OVERALL HEALTH AND FUNCTION:

Please rate your Mental Health and Functioning Level on this scale:

(0=Worst ever ..... 100= "normal" or optimal mental health)

Current rating?	0	10	20	30	40	50	60	70	80	90	100
Highest rating you've ever experienced?	0	10	20	30	40	50	60	70	80	90	100

Anything else you think we should know?_____

_____

_____

_____

Thank you for taking the time to provide this information. It will help us *understand your experience with depression and how to best* serve *you.*