The TMS Center of New Jersey

55 North Gilbert Street Suite 2203
Tinton Falls, NJ 07701

Kerry Kornett APN
732-842-0505 Telephone
732-842-0100 FAX

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip: _____ Marital Status: S ☐ M ☐ D ☐ W ☐ Gender: M ☐ F ☐ Other ☐

Home # : _____ Work # : _____Cell #: _____

Fax # : _____ Email: _____

Employment Status: FT ☐ PT ☐ Student ☐ Disabled ☐ Retired ☐

Type of Employment: _____

Emergency Contact : _____ Relationship: _____

Phone # : _____

RESPONSIBLE PARTY INFORMATION (if other than patients)

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone # : _____

INSURANCE INFORMATION (Please attach a copy of insurance card(s) front and back if available)
Primary Insurance: _____Insurance Phone: _____

Subscriber ID # : _____ Subscriber Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Subscriber: Self ☐ Spouse ☐ Other ☐

Secondary Insurance: _____Insurance Phone: _____

Subscriber ID # : _____ Subscriber Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Subscriber: Self ☐ Spouse ☐ Other ☐

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PRIMARY CARE PHYSICIAN INFORMATION

Physician Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

FAX: _____ Email: _____

Dates Under Physician care: From: _____ To: _____ Date of last visit: _____

THERAPIST INFORMATION (IF APPLICABLE)

Clinician Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

FAX: _____ Email: _____

Dates Under Clinician care: From: _____ To: _____ Date of last visit: _____

Do you consent to Therapist sharing treatment updates? Y ☐ N ☐ Sign Here*_____

PSYCHIATRIC HISTORY

Presenting problem: Describe the problems you are having and when they began:

_____

_____

_____

_____

_____

_____

_____

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SYMPTOM CHECKLIST: Please check any symptoms you are experiencing.

___ Aggression/Anger Outbursts
___ Dizziness
___ Anxiety
___ Avoidance of people
___ Chest Pains
___ Depression
___ Difficulty Concentrating
___ Sleeping Problems
___ Withdrawal
___ Difficulty Thinking
___ Distractibility
___ Eating Disorders
___ Elevated Mood
___ Fatigue
___ Indecisiveness
___ Muscle Tension
___ Suicidal Thoughts
___ Worthlessness
___ Gambling
___ Hallucinations
___ Headaches
___ Helplessness
___ Hopelessness
___ Irritability
___ Loneliness
___ Impulsivity
Other Symptoms _____
___ Memory Problems
___ Mood Swings
___ Worrying
___ Panic Attacks
___ Racing Thoughts
___ Restlessness
___ Sexual Difficulties
___ Weight Gain

CURRENT STRESSORS: Please check all that apply.

___ Marital Conflict
___ Financial Problems
___ Conflict with Children
___ Conflict with Parents
___ Conflict with Siblings
___ Poor Peer Relations
___ Health Problems
___ Job loss or change
___ Problems at School
___ Recent Move
___ Legal Problems
___ Recent Death
___ Substance Abuse Problems
___ Housing Problems
___ Other (list) :_____

PAST HISTORY OF MENTAL HEALTH PROBLEMS/TREATMENT:

Prior outpatient treatment: Y ☐ N ☐

Date: _____ to _____Clinician : _____ City/State: _____

Date: _____ to _____Clinician : _____ City/State: _____

Date: _____ to _____Clinician : _____ City/State: _____

Prior Psychiatric Hospitalizations: Y ☐ N ☐
Date: _____ to _____ Hospital Name/State: _____

Date: _____ to _____ Hospital Name/State: _____

Alcohol / Caffeine / Tobacco / Drugs			
	Quantity	Frequency	Last Use
Alcohol			
Caffeine			
Tobacco			
Marijuana			
Other Drugs of Abuse			
Drug	Quantity	Frequency	Last Use

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NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE (CONT'D)

Patient Name: _____

Prescription medications you are currently taking:

Prescription Medication	Dosage	Frequency

Vitamins, supplements or homeopathic medications you are currently taking:

Vitamins / Supplements / Homeopathic	Dosage	Frequency

List all medical problems you have been or are currently being treated for:

List all surgeries you have had:

Procedure	Date	Outcome

Allergies, including medications: No known allergies ☐

Allergy / Medication	Reaction

Date of last physical: _____

WOMEN

Are you pregnant? Yes ☐ No ☐

Date of L.M.P. _____

Continued on next page