The TMS Center of New Jersey

55 North Gilbert Street Suite 2203
Tinton Falls, NJ 07701

732-842-0505 Telephone
732-842-0100 FAX

PATIENT DEMOGRAPHIC

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 # : _____

PRIMARY 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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PSYCHIATRIST INFORMATION

Physician Name: _____ Address: _____

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

FAX: _____ Email: _____

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

THERAPIST INFORMATION (IF APPLICABLE)

Therapist Name: _____ Address: _____

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

FAX: _____ Email: _____

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

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

PSYCHIATRIC HISTORY

PAST HISTORY OF MENTAL HEALTH PROBLEMS/TREATMENT:

Prior Psychiatric Hospitalizations: Y ☐ N ☐

Prior Partial Hospitalization program/ Intensive outpatient program: Y ☐ N ☐

Date: _____ to _____ Hospital Name/State: _____

Date: _____ to _____ Hospital Name/State: _____

Date: _____ to _____ Hospital Name/State: _____

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PSYCHIATRIC MEDICATION HISTORY:

CURRENT MEDICATIONS

MEDICATION	DOSAGE	START AND END DATES	RESPONSE

PAST PSYCHIATRIC MEDICATION TRAILS

MEDICATION	DOSAGE	START AND END DATES	RESPONSE

ALLERGIES, INCLUDING MEDICATIONS:

Allergy/Medication	Reaction

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Do you have any implanted metal objects around your Head or Neck?

Y ☐ N ☐

If yes, please explain: _____

Do you have a history of seizures? Y ☐ N ☐

If yes, when was your last seizure: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **AGE:** _____ **DATE:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use "√" to indicate your answer)*	0 Not at all	1 - 2 Several days	3 - 4 More than half the days	16+ > 5 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 figety 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, please refer to accompanying scoring card). TOTAL: