Indianapolis TMS
Consultation Form – Client Report Part A

Client Name: _____ DOB: _____
Referring Professional: _____ Release of Info signed: ____

Psychiatric Medication List:

	MEDICATION	START DATE	END DATE	HIGHEST DOSE	PRESCRIBER	RESULTS/SIDE EFFECTS
	SSRI'S					
	Celexa					
	Lexapro					
	Prozac					
	Luvox					
	Paxil					
	Zoloft					
	Viibryd					
	Trintellix					
	SNRI'S					
	Cymbalta					
	Pristiq					
	Effexor (XR)					
	Fetzima					
	Other Antidepressants					
	Wellbutrin					
	Trazodone					
	Remeron/Mirtazapine					
	SDAM/Adjunctive Tx					
	Rexulti					
	Abilfy					
	Latuda					
	Zyprexa					
	Seroquel					
	Risperdal					
	Geodon					
	Lithium					
	Buspar					
	Topamax					
	Neurontin					
	Gabitril					
	Lamictal					
	Vraylar					

Over the Counter Medications/Vitamins:

_____

_____

FAMILY HISTORY:

Father's Name, mental health history:

_____

_____

Mother's Name, mental health history:

_____

_____

Siblings, mental health history:

_____

_____

Other family member's mental health history:

_____

_____

_____

MEDICAL HISTORY:

OPERATIONS: _____

HOSPITALIZATIONS: _____

MEDICAL ISSUES: _____

ALLERGIES: _____

MENTAL HEALTH OR ADDICTION TREATMENT:

Facility, Dates, Benefit/Outcome

_____

_____

_____

_____

_____

Current Therapist	**Psychiatrist**	**Internist**
_____	_____	_____
Name	Name	Name
_____	_____	_____
Phone Number	Phone Number	Phone Number

MENTAL HEALTH SYMPTOMS:

Depression:

Anxiety:

Obsessive Compulsive Disorder:

Other:

SUBSTANCE ABUSE/ADDICTION HISTORY: (Frequency, amount, recovery, etc.)

Alcohol:

Marijuana:

Nicotine:

Cocaine/Crack/Meth:

Opiates/Pain Medications/Benzos

Additional Information: