

## Transcranial Magnetic Stimulation Screening Questionnaire

Before you are able to receive TMS treatment, we need to make sure that it is safe for you to do so. To that end, we need information about the possible factors that could enhance your risk to experience unintentional adverse effects. Please fill out the questionnaire carefully and honestly. This form will subsequently be assessed by a physician.

**First and last name:**

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Please also place your initials at the bottom of each page

### Screening questionnaire

1) Do you have epilepsy?  Yes  No  
If yes, please specify: \_\_\_\_\_

2) Have you ever had a convulsion or a seizure?  Yes  No  
If yes, please specify: \_\_\_\_\_

3) Does someone in your family have epilepsy?  Yes  No  
If yes, how are you related to this person? \_\_\_\_\_

4) Have you ever lost consciousness without any known reason?  Yes  No  
If yes, please describe when and how this occurred: \_\_\_\_\_

5) Have you ever had a severe head trauma?  Yes  No  
If yes, please specify: \_\_\_\_\_

6) Have you ever had a stroke?  Yes  No  
If yes, please specify: \_\_\_\_\_

7) Have you ever undergone surgery to your head?  Yes  No  
If yes, please specify: \_\_\_\_\_

Initials \_\_\_\_\_



8) Do you have any of the following implants in your body?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| <input type="checkbox"/> (metal) Plates and/or screws            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Vascular clips                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Artificial heart valve                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Metallic splinters/shrapnel/etc.        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Pacemaker                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Insulin pump                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Internal hearing aid (cochlear implant) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Any other implant not mentioned above   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered "yes" to any of the questions above, please specify:

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9) Do you have any deviations of the spinal cord, bone marrow, or the ventricular system (spaces in the brain filled with liquid)?  
If yes, please specify:

- Yes       No

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10) Do you have any hearing disabilities or ringing in your ears?  
If yes, please specify:

- Yes       No

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11) Have you ever (at present or in the past) suffered from a brain-related, neurological illness?  
If yes, please specify:

- Yes       No

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12) Do you suffer from frequent severe headaches?  
If yes, please describe how often, and on which occasions:

- Yes       No

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13) Are you currently under any form of medical treatment?  
If yes, please specify:

- Yes       No

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14) Are you currently taking antibiotics (a medication that helps alleviate bacterial infections)?

- Yes       No

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15) Do you ever take antihistamines (anti-allergy medication)?  
If yes, how often and when was the last time you took them?

- Yes       No

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16) Are you taking any other medications not mentioned above?  
If yes, please list:

- Yes       No

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Initials \_\_\_\_\_



17) Do you have a chronic illness/disorder?  Yes  No  
 If yes, please specify: \_\_\_\_\_

18) Have you ever (at present or in the past) had a psychiatric-based illness/disorder?  Yes  No  
 If yes, please specify: \_\_\_\_\_

19) Does someone in your family have a psychiatric-based illness/disorder?  Yes  No  
 If yes, please specify: \_\_\_\_\_

How are you related to this person?  
 \_\_\_\_\_

20) Have you used any recreational drugs during the past year (such as marijuana, ecstasy, cocaine, etc.)?  Yes  No  
 If yes, please specify which drugs did you use, and when was the last time that you used them?  
 \_\_\_\_\_

21) Have you ever suffered from substance dependence or abuse?  Yes  No  
 If yes, please specify: \_\_\_\_\_

22) Do you averagely consume more than 3 alcoholic units a day?  Yes  No  
 \_\_\_\_\_

23) Do you have sleeping problems?  Yes  No  
 If yes, please specify: \_\_\_\_\_

24) Are you pregnant, or is there a chance that you might be?  Yes  No  
 \_\_\_\_\_

25) Have you ever undergone an MRI for clinical purposes?  Yes  No  
 If yes, did any problems occur during scanning?  Yes  No  
 If yes, please specify: \_\_\_\_\_

26) Have you ever undergone TMS?  Yes  No  
 If yes, have you ever had an adverse reaction to TMS?  Yes  No  
 If yes, please specify: \_\_\_\_\_

Initials \_\_\_\_\_



I answered all questions to the best of my knowledge and belief:

Signature: \_\_\_\_\_

Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Review of Past Treatments**

Unable to function at home

Unable to function at work

Evidence of at least four Medications Trials from earliest to latest, including two different agent classes, during this episode.

Medication Class	Med Name	Max Dose	Time Period	Response	Side Effects	Current Med
SSRIs						
SNRIs						
NDRIs						
TCA's						
MAOIs						
Other						

List any augmentation strategies tried in the table below:

Strategy	Max Dose	Response	Side Effects	Notes
Lithium				
Thyroid Hormone				
Stimulants				
Dual Anti-Depressants				
Psychotherapy				
ECT				
Ketamine				

Level of Care	Number of Admission/Sessions	Date/s	Response
Inpatient			
Residential			
Partial/Day Treatment			
Intensive Outpatient Treatment			
Outpatient Therapy			

Other Therapies? (Describe date of treatment and effectiveness): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Initials \_\_\_\_\_

