

Thank you for choosing Collaborative Minds for treating your depression.

We provide patients in Baton Rouge, Louisiana and surrounding areas the latest in depression treatments. We are pleased to be able to offer [Neurostar® TMS Therapy](https://www.tmsacadiana.com/neurostarTMSTherapy/index.php) to our patients. [Transcranial Magnetic Stimulation Therapy](https://www.tmsacadiana.com/transcranialmagneticstimulation/index.php) is one of the most technologically advanced [depression treatments](https://www.tmsacadiana.com/depression-tms/treating-depression-tms.php) available. This non-invasive, outpatient therapy is FDA cleared and has helped thousands of depression patients who have not received adequate results from antidepressants.

Please keep in mind that all of the New patient packet must be completely filled out before our staff members schedule you for a TMS consult with Dr. Larry Warner.

If you have any questions, please call Lauren our TMS coordinator.

225-456-2884



10157 Kentshire Court TMS New Patient Paperwork

Baton Rouge, LA 70818 **PLEASE PRINT**

(225)400-9443 – Lauren (TMS Coordinator)

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| **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referring Physician:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Patient Demographics** |
| **First Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****SSN (for insurance purposes): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_****Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Preferred Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Insurance** |
| **Insurance Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Member ID:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Subscriber Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SSN:** \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_**Contact Number:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please **READ BELOW** this is very important concerning your insurance:* Patients with insurance: If our office is contracted with your insurance company, we will file your insurance claim if you provide us with the PROPER information along with a copy of your current insurance card. If your insurance DOES NOT pay within 90 days, you are responsible for the remaining balance and you will be billed accordingly, this includes your insurance being denied for Coordination of Benefits, pre-existing etc. it is your responsibility to know and understand your benefits.
* **ALL COPAYMENTS, DEDUCTIBLES OR COINSURANCE PAYMENTS ARE DUE AT THE TIME OF SERVICE. WE DO NOT BILL PATIENTS.** We accept all forms of payment except for personal checks. If payment cannot be made at the time of service your appointment will be cancelled and you will have to reschedule.
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**Please bring new paperwork to our office Monday-Friday between 8:00 am - 2:00 pm**

**With your license and insurance card. If faxing, please send to (225) 456-2892.**

**Or email it to** **walkerlauren10@yahoo.com**

**ALL TMS PATIENT APPOINTMENTS ARE MONDAY – FRIDAY / 8:00 AM – 3:00 PM ONLY**

 **NO EXCEPTIONS**



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| **DISCLOSURE INFORMATION:**I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AUTHORIZE Collaborative Minds to discuss my case including medical diagnoses, appointments, medication, medical history, coordination of care and progress note documentations from my visits with **ONLY THE FOLLOWING PEOPLE. IF YOU WISH TO NOT HAVE INFORMATION RELEASED TO ANYONE LEAVE BLANK**.Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School, Work, Office:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Healthcare Provider, Therapist, PCP etc.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If there should be any additions to this list, I will need to sign and additional authorization to release form. I authorize Collaborative Minds to collaborate with my insurance if they are to request information regarding my Coordination of Care. This may include a review of records for quality of treatment. Acknowledgement of Release of Information for Insurance purposes: \_\_\_\_\_\_\_\_\_\_\_\_ - **INITIAL** |
| **ALL TMS THERAPY PATIENTS ARE TO CANCEL THEIR APPOINTMENTS 24 HOURS IN ADVANCE**.All appointments not cancelled in 24 HOURS in advanced will becharged the **$50.00** fee the same day**. THIS WILL BE CHARGED TO THE CARD THAT YOU ARE REQUIRED TO HAVE ON FILE.** If payment is not received, you will be responsible for this payment before you can reschedule. Patients with excessive missed appointments will be given a warning, followed by termination from care for the next missed appointment. It is your responsibility to remember your appointment. Automatic reminder calls are done **TWO** days prior to your appointment. **Signature of Acknowledgement of our No-Show Policy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Credit Card/ Debit Card Information** – **THIS IS NOT AN OPTION**Your credit card will need to be updated when it expires. Failure to update card information in a timely manner may have interfere with your ability to make future appointments until updated information is received. I, the undersigned, understand that this form will be valid for the duration of my treatment with Collaborative Minds.SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_This card will only be used for new patient deposit, missed appointments and if you forget your card at the time of your scheduled appointment. If you are not the card holder then we will need the card holder’s signature, phone number and a copy of their driver’s license. |

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| **Please circle** | **VISA** | **MASTERCARD** | **AMERICAN EXPRESS** |

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| **Patient Name:** |
| **Card Holder Name:** |
| **Card Number:** |
| **CCV: / Expiration Date:** |
| **Signature of Card Holder:** |



**NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE**

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| **Medical/Psychological History** |

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| Seizure **Yes No** | Hearing Loss **Yes No** |
| Head Trauma **Yes No** | Tinnitus **Yes No** |
| Stroke **Yes No** | Claustrophobia **Yes No** |
| Diabetes **Yes No** | Restless Leg Syndrome **Yes No** |
| Severe Headaches **Yes No** | Dementia **Yes No** |
| Neurological Disease **Yes No** | Dizziness **Yes No** |
| Parkinson’s Disease **Yes No** | Thyroid Problems **Yes No** |
| High Blood Pressure **Yes No** | Bipolar Disorder **Yes No** |
| Schizoaffective Disorder **Yes No** | Manic Episodes **Yes No** |

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| **Substance/Drug Use** |

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| **Drug** | **Quantity** | **Frequency** | **Last Use** |
| Alcohol |  |  |  |
| Tobacco |  |  |  |
| Marijuana |  |  |  |
| Other: |  |  |  |

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| Have you ever been treated for alcohol/drug abuse?  |
| **Date:** **Facility:** **Effectiveness:** |

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| **Family Psychiatric History** |
| Has anyone in your family been diagnosed with or treated for: |

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| Bipolar Disorder **Yes No** | Post-Traumatic Stress **Yes No** |
| Schizophrenia **Yes No** | Alcohol Abuse **Yes No** |
| Depression **Yes No** | Substance Abuse **Yes No** |
| Anxiety **Yes No** | Suicide **Yes No** |

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| **Allergies, including medications:****\_\_\_\_ No known allergies** |
|  **Allergy/Medication Reaction** |

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| Suicide Attempt(s) **Yes No** | If yes, when? |
| Thoughts of Suicide **Yes No** |  |
| Psychiatric Hospitalization(s) **Yes No** |  |
| **Name of Facility** | **Date** |
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| **Have you ever had ECT/DBS? Yes No Explain:** |

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| **Date** | **Outcome** | **Unilateral/Bilateral/NA** |
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| **THERAPY:****please list the name of your therapist, company, and the amount of time you have seem them.** |

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| **Name of Therapist** | **Name of Facility** | **Start Date/End Date** | **Current** |
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| **List all surgeries you have had:** |

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| **Procedure** | **Date** | **Outcome** |
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| **Psychiatric History** |



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| **Do you have and implanted metal objects around the head?** |
| Plates: \_\_ Yes \_\_No If yes, where? |
| Piercings: \_\_ Yes \_\_ No If yes, where? |
| Staples/Screws: \_\_ Yes \_\_ No If yes, where? |
| Stents: \_\_ Yes \_\_ No If yes, where? |
| Dental Implants: \_\_ Yes \_\_ No If yes, where? |
| Bullet Fragments: \_\_ Yes \_\_ No If yes, where? |
| Shrapnel Fragments: \_\_ Yes \_\_ No If yes, where? |
| Aneurysm Coils: \_\_ Yes \_\_ No If yes, where? |
| Cochlear Implants: \_\_ Yes \_\_ No If yes, where? |
| Ocular Implants: \_\_ Yes \_\_ No If yes, where? |
| Deep Brain Stimulation Device: \_\_\_ Yes \_\_\_ No |
| Other: Explain: |
| **Do you have any of the following?** |
| Pacemaker: \_\_\_ Yes \_\_\_ No |
| Hearing Aid: \_\_\_ Yes \_\_\_ NoRemovable? \_\_\_ Yes \_\_\_ No |
| Implantable Cardiac Defibrillator (I.C.D): \_\_\_Yes \_\_\_No |
| Wearable Cardiac Defibrillator (W.C.D.): \_\_\_ Yes \_\_\_No |
| Vaginal Nerve Stimulator: \_\_\_ Yes \_\_\_No |
| Spinal Cord Stimulator: \_\_\_ Yes \_\_\_No |
| Implantable Drug Pump: \_\_\_ Yes \_\_\_No |
| Insulin Pump: \_\_\_ Yes \_\_\_No |
| Do you have anything not mentioned above implanted on your body?Explain: |
| **WOMEN ONLY:** Are you Pregnant? \_\_\_Yes \_\_\_No / **If yes, how far along?** |
| **I Certify that the information listed above is true and correct:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient Signature Date** |



**Please list the dates that you’ve taken the medications to the best of your ability. If you are not sure of the dates, you are more than welcome to call your pharmacy. ALSO, THE STRENGTH OF THE MEDICATIONS. They can give you a list of all your previous medications.**

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| **Brand Name/ Generic name** | **Current** | **Dosage (mg)****Directions** | **Start Date** | **Stop Date** | **Why Discontinued** |
| **SSRI** |  |  |  |  |  |
| Prozac / Fluoxetine**/F** |  |  |  |  |  |
| Zoloft / Sertraline |  |  |  |  |  |
| Paxil/ Paxil CR / Pexeva / Paroxetine |  |  |  |  |  |
| Lexapro / Escitalopram |  |  |  |  |  |
| Luvox / Fluvoxamine |  |  |  |  |  |
| Viibryd / Vilazodone |  |  |  |  |  |
| **SNRI** |  |  |  |  |  |
| Effexor XR / Venlafaxine |  |  |  |  |  |
| Cymbalta / Duloxetine |  |  |  |  |  |
| Pristiq / Desvenlafaxine |  |  |  |  |  |
| Fetzima / Levomilnacipran |  |  |  |  |  |
| Savella / Milnacipran |  |  |  |  |  |
| **OTHER ANTIDEPRESSANTS** |  |  |  |  |  |
| Wellbutrin / Aplenzin / Zyban / Bupropion |  |  |  |  |  |
| Desyrel / Oleptro / Trazodone |  |  |  |  |  |
| Remeron / Mirtazapine |  |  |  |  |  |
| Trintellix / Vortioxetine |  |  |  |  |  |
| **TETRACYCLIC/ TCA** |  |  |  |  |  |
| Elavil / Endep / Amitriptyline |  |  |  |  |  |
| Pamelor / Aventyl / Nortriptyline |  |  |  |  |  |
| Sinequan / Silenor / Doxepin |  |  |  |  |  |
| **Mood Stabilizers** |  |  |  |  |  |
| Lithobid / Eskalih / Lithium |  |  |  |  |  |
| Lamictal / Lamotrigine |  |  |  |  |  |
| Depakote / Valporate |  |  |  |  |  |
| **Atypical Antipsychotics** |  |  |  |  |  |
| Abilify / Aripirazole |  |  |  |  |  |
| Seroquel / Quetiapine |  |  |  |  |  |
| Risperdal / Risperidone |  |  |  |  |  |
| Saphris / Asenapine |  |  |  |  |  |
| Zyprexa / Symbyax / Olanzapine |  |  |  |  |  |
| Latuda / Lurasidone |  |  |  |  |  |
| Invega / Paliperidone |  |  |  |  |  |
| Rexulti / Brexpiprazole |  |  |  |  |  |

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| **1. Has there ever been a period of time when you were not your normal self and…** | **Yes** | **No** |
| … you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? |  |  |
| … you were so irritable that you shouted at people or started fights or arguments? |  |  |
| … you got much more self – confident that usual? |  |  |
| … you got much less sleep than usual and found that you didn’t really miss it? |  |  |
| … you were much more talkative or spoke much faster than usual? |  |  |
| … thoughts raced through your head or you couldn’t slow your mind down? |  |  |
| … you were so easily distracted by things around you that you had trouble concentrating or staying on track? |  |  |
| … you had much more energy than usual? |  |  |
| … you were much more active or did many more things than usual? |  |  |
| … you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? |  |  |
| … you were much more interested in sex than usual? |  |  |
| … you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? |  |  |
| … spending money got you or your family in trouble? |  |  |



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| **2. If you checked *YES* to more than one of the above:** | **Yes** | **No** |
| Have several of these ever happened during the same period of time? |  |  |

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|  | **No****Problem** | **Minor****Problem** | **Moderate****Problem** | **Serious****Problem** |
| 3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments and fights? |  |  |  |  |

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|  | **Yes** | **No** |
| Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? |  |  |

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|  | **Yes** | **No** |
| Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? |  |  |



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| **PH-Q9 (PATIENT HEALTH QUESTIONARRE)** |

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| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | **Not at all** | **Several****Days** | **More****Than****half the****days** | **Nearly****Every****Day** |
| **1.** Little interest or pleasure in doing things. |  |  |  |  |
| **2.** Feeling down, depressed, or hopeless. |  |  |  |  |
| **3.** Trouble falling or staying asleep or sleeping too much. |  |  |  |  |
| **4.** Feeling tired or having little energy. |  |  |  |  |
| **5.** Poor appetite or overeating. |  |  |  |  |
| **6.** Feeling bad about yourself or that you are a failure or have let yourself or your family down. Trouble concentrating on things, such as reading the newspaper or watching television. |  |  |  |  |
| **7.** Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual. |  |  |  |  |
| **8.** Thoughts you would be better off dead or of hurting yourself. |  |  |  |  |

**10. if you circled any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?**

\_\_\_ Not difficult at all \_\_\_ Somewhat difficult \_\_\_ Very difficult \_\_\_ Extremely difficult