



NEW PATIENT INFORMATION SHEET

Patient Information –

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security #: _____ Gender: **M** **F** Marital Status: **•S** **•D** **•M** **•W** **•Domestic Partner**
Home Phone: _____ Work Phone: _____ Cellular Phone: _____
Patient's Primary Language: English _____ Other (specify) _____
Emergency Contact _____ Relationship: _____:
Phone: _____ Work/Cell: _____:

Responsible Party Information (if other than the patient) –

Name: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cellular Phone: _____

Primary Insurance Information – *(Please attach a copy – front & back of insurance card(s) if available.)*

Primary Insurance: _____ Insurance Phone #: _____ Subscriber ID #: _____
Subscriber: _____ Relationship to Subscriber: Self Spouse Other
Group #: _____ Is Provider Contracted with This Insurance? Yes No Unknown

Secondary Insurance Information – *(Please attach a copy – front & back of insurance card(s) if available.)*

Secondary Insurance: _____ Insurance Phone #: _____ Subscriber ID #: _____
Subscriber: _____ Relationship to Subscriber: Self Spouse Other
Group #: _____ Is Provider Contracted with This Insurance? Yes No Unknown

Primary Care Physician Information -

Name: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
Email Address: _____ Name of Office Contact: _____
Date of last visit: _____



Psychotherapist Information –

Name: _____

Address: _____

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

Email Address: _____ Name of Office Contact: _____

Date of last visit: _____

Signature / Authorization

I authorize the release of any medical information necessary to process my claim.

I hereby authorize examination and whatever services deemed necessary. I agree to assume financial responsibility for all services provided.

I authorize the release of any medical information to the primary care physician and psychotherapist listed above.

Signature of Patient or Responsible Party: _____

Date: _____



NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Information –

Patient Name: _____ Date of Birth: _____

MEDICAL QUESTIONNAIRE –

Do you have any implanted metal objects around the head?

Piercings **Yes No** If yes, where? _____ Removable? **Yes No**

Plates: **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**

Cochlear Implants **Yes No**

Ocular Implants **Yes No**

Deep Brain Stimulation Device **Yes No**

Do you have anything not mentioned above implanted in the head area? **Yes No**

If yes, where? _____ Removable? **Yes No**

Do you have any of the following:

Pacemaker **Yes No**

Hearing Aid **Yes No** Removable? **Yes No**

Implantable Cardiac Defibrillator (I.C.D.) **Yes No**

Wearable Cardiac Debibrilator (W.C.D.) **Yes No**

Vegal Nerve Stimulator (V.N.S.) **Yes No**

Spinal Cord Stimulator **Yes No**

Implantable Drug Pump **Yes No** If yes, where?

Insulin Pump **Yes No** If yes, where?

Do you have anything not mentioned above implanted in your body? **Yes No**

If yes, where? _____ Removable? **Yes No**

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Patient Information –

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY –

What prescription medications are you currently taking, include frequency:

What Vitamins, supplements and homeopathic medications are you currently taking, include frequency:

List all medical problems you have/had:

What surgeries have you had:

Any Allergies, including medication: (Please list) Yes No

Date of Last Physical:

WOMEN

Are you pregnant **Yes No**

Date of L.M.P.

Patient Information –

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY CONTINUED –

Do you have / had any of the following:

Seizure	Yes	No		
Head Trauma	Yes	No		
Stroke	Yes	No		
Brain Tumors	Yes	No		
Severe Headaches	Yes	No		
Eye Pain	Yes	No		
Toothache	Yes	No		
Hearing Loss	Yes	No		
Ringing in your ears	Yes	No		
Claustrophobia	Yes	No		
Restless Leg Syndrome	Yes	No		
High Blood pressure	Yes	No		
Low Blood Pressure	Yes	No		
Dizziness	Yes	No		
Drink Alcohol	Never	Rarely	Socially	Daily
Use Tobacco Products	Never	Rarely	Socially	Daily
Take Drugs	Never	Rarely	Socially	Daily

MENTAL HISTORY–

Suicide Attempt(s)	Yes	No	
Thoughts of suicide	Yes	No	
Psychiatric Hospitalization	Yes	No	If Yes, dates: _____

Signature / Authorization

I certify that the above is true and correct

Signature of Patient or Responsible Party: _____

Date: _____



Patient Consent for a Medical Procedure

NeuroStar TMS Therapy

This is a patient consent for a medical procedure called NeuroStar TMS Therapy[®]. This consent form outlines the treatment that Dr. Hutton has prescribed for you, the risks of this treatment, the potential benefits of this treatment to you, and any alternative treatments that are available for you if you decide not to be treated with NeuroStar TMS Therapy.

The information contained in this consent form is also described in the Depression Patient's Manual for Transcranial Magnetic Stimulation with the NeuroStar TMS Therapy[®] System which is available from Southern California TMS Center. Not all information in the Manual is stated here, so you should read the Patient Manual and discuss any questions that you have with your doctor. Once you have reviewed the manual and this consent form, be sure to ask a member of the Southern California TMS Center staff any questions that you may have about NeuroStar TMS Therapy.

Dr. Hutton has explained the following information to me:

- a. TMS stands for "Transcranial Magnetic Stimulation". NeuroStar TMS Therapy is a medical procedure. A TMS treatment session is conducted using a device called the NeuroStar TMS Therapy System, which provides electrical energy to a "treatment coil" or magnet that delivers pulsed magnetic fields. These magnetic fields are the same type and strength as those used in magnetic resonance imaging (MRI) machines.
- b. NeuroStar TMS Therapy is a safe and effective treatment for patients with depression who have not benefitted from antidepressant medications.
- c. Specifically, NeuroStar TMS Therapy has been shown to relieve depression symptoms in adult patients who have been treated with one antidepressant medication given at a high enough dose and for a long enough period of time but did not get better.

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- d. At this time, there are no studies that show that NeuroStar TMS Therapy works for patients who did not get better after taking two or more antidepressant medications at a high enough dose and for a long enough period of time or who did not take any antidepressants during this current period of depression.
- e. During a TMS treatment session, Dr. Hutton or a member of the Southern California TMS Center staff will place the magnetic coil gently against my scalp on the left front region of my head. The magnetic fields that are produced by the magnetic coil are pointed at a region of the brain that scientists think may be responsible for causing depression.
- f. To administer the treatment, Dr. Hutton or a member of the Southern California TMS Center staff will first position my head in the head support system. Next, the magnetic coil will be placed on the left side of my head, and I will hear a clicking sound and feel a tapping sensation on my scalp. The doctor will then adjust the NeuroStar TMS Therapy system so that the device will give just enough energy to send electromagnetic pulses into the brain so that my right hand twitches. The amount of energy required to make my hand twitch is called the “motor threshold”. Everyone has a different motor threshold and the treatments are given at an energy level that is just above my individual motor threshold. How often my motor threshold will be re-evaluated will be determined by Dr. Hutton or a member of the Southern California TMS Center staff.
- g. Once motor threshold is determined, the magnetic coil will be moved, and I will receive the treatment as a series of “pulses” that last about 4 seconds, with a “rest” period of about 26 seconds between each series. Treatment is to the left front side of my head and will take about 40 minutes. I understand that this treatment does not involve any anesthesia or sedation and that I will remain awake and alert during the treatment. I will likely receive these treatments 5 times a week for 4 to 6 weeks (20 to 30 treatments). I will be evaluated by Dr. Hutton periodically during this treatment course. The treatment is designed to relieve my current symptoms of depression.

h. During the treatment, I may experience tapping or painful sensations at the treatment site while the magnetic coil is turned on. These types of sensations were reported by about one third of the patients who participated in the research studies. I understand that I should inform the Dr. Hutton or a member of the Southern California TMS Center staff if this occurs. The doctor may then adjust the dose or make changes to the where the coil is placed in order to help make the procedure more comfortable for me. I also understand that headaches were reported in half of the patients who participated in the clinical trial for the NeuroStar device. I understand that both discomfort and headaches got better over time in the research studies and that I may take common over-the-counter pain medications such as acetaminophen if a headache occurs.

i. The following risks are also involved with this treatment:

The NeuroStar TMS Therapy System should not be used by anyone who has magnetic-sensitive metal in their head or within 12 inches of the NeuroStar magnetic coil that cannot be removed. Failure to follow this restriction could result in serious injury or death. Objects that may have this kind of metal includes:

- Aneurysm clips or coils
- Stents
- Implanted Stimulators
- Electrodes to monitor your brain activity
- Ferromagnetic implants in your ears or eyes
- Bullet fragments

j. Other metal devices or objects implanted in the head. NeuroStar TMS Therapy is not effective for all patients with depression. Any signs or symptoms of worsening depression should be reported immediately to your doctor. You may want to ask a family member or caregiver to monitor your symptoms to help you spot any signs of worsening depression.

