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PATIENT INFORMATION:

NAME: _____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** _____

WHAT BRINGS YOU TO THE OFFICE TODAY?

_____

_____

_____

_____

REFERRED BY: _____ PRIMARY CARE PHYSICIAN: _____

WHAT EVENTS TOOK PLACE THAT MAY HAVE MADE YOU FEEL LIKE THIS?

_____

_____

_____

_____

HAVE YOU EVER HAD TREATMENT FOR THIS PROBLEM? (Medications, therapy, tests, etc.)

_____

_____

_____

_____

HOW WOULD YOU DESCRIBE YOUR MOOD?

SAD		HAPPY		ANXIOUS		FEARFUL		ANGRY	
IRRITABILE		EUPHORIC		OTHER:					

HOW WOULD YOU DESCRIBE YOUR SLEEP?_____

HOW WOULD YOUR DESCRIBE YOU ENERGY?_____

HOW WOULD YOU DESCRIBE YOUR CONCENTRATION?_____

HOW WOULD YOU DESCRIBE YOUR APPETITE?_____

ARE YOU EASILY FRUSTRATED? IF SO, HAS IT BECOME WORSE?_____

HAS YOUR SEXUAL DESIRE CHANGED? INCREASE OR DECREASE?_____

ARE YOU NOW OR HAVE YOU EVER BEEN SUICIDAL?_____

DO YOU HAVE OBSESSSIVE THOUGHTS OR BEHAVIORS?_____

DO YOU EVER FEEL WORTHLESS, HOPELESS, HELPLESS, OR GUILTY?_____

DO YOU EVER FEEL YOU'VE LOST YOUR ABILITY TO FEEL JOY?_____

DO YOU SEE VISIONS OR HEAR VOICES?_____

DO YOU EVER FEEL THAT PEOPLE ARE WATCHING YOU, FOLLOWING YOU, OR WHISPERING ABOUT YOU?_____

MEDICAL DIAGNOSIS AND PROBLEMS:

- DO YOU HAVE ANY METAL IMPLANTS?
- DO YOU HAVE ANY MEDICAL IMPLANTS?
- HAVE YOU EVER HAD A SEIZURE?
- HAVE YOU EVER BEEN DIAGNOSISED WITH OBSTRUCTIVE SLEEP APNEA?
- ARE YOU ON A SPECIAL DIET?

ALLERGIES:

PAST SURGERIES:

PAST HOSPITALIZATIONS:

MEDICATIONS: (please list all medications you are currently taking including how often and dosage)

MEDICATION:	DOSAGE (mg)	HOW MANY TIMES A DAY?	ON FOR HOW LONG?	SIDE EFFECTS?	WHO PRESCRIBES IT?

THIS SECTION MUST BE COMPLETED or list attached

If you do not take any medications please check here _____

ALLERGY				ENT			
Runny nose	yes		no	Cold	yes		no
Scratchy throat	yes		no	Nose bleeds	yes		no
Itchy eyes	yes		no	Hearing loss	yes		no
Ear fullness	yes		no	Sore thorat	yes		no
Sinus congestion	yes		no	Ringing in the ears	yes		no
RESPIRATORY				Sinus pain	yes		no
Short of breath	yes		no	**FEMALES**			
Chest congestion	yes		no	Menopause	yes		no
Cough	yes		no	Heavy periods	yes		no
CARDIOLOGY				Painful periods	yes		no
Chest pain	yes		no	Breast pain	yes		no
Palpitations	yes		no	Pelvic pain	yes		no
Swelling of the legs	yes		no	**MALES**			
Varicose veins	yes		no	Difficulty with errections	yes		no
CONSTITUTIONAL				Enlarged prostate	yes		no
Weight gain	yes		no	**GASTRO**			
Loss of appetite	yes		no	Nausea	yes		no
Fever	yes		no	Heartburn	yes		no
Weakness	yes		no	Vomiting	yes		no
Weight loss	yes		no	Abdominal pain	yes		no
Fatigue	yes		no	Difficulty swallowing	yes		no
DERMATOLOGY				Diarrhea	yes		no
Rash	yes		no	Constipation	yes		no
Moles	yes		no	**HEMATOLOGY**			
Lumps	yes		no	Swollen glands	yes		no
Dry or sensitive skin	yes		no	Swollen Lymph nodes	yes		no
Hives	yes		no	Easy bruising	yes		no
Skin cancer	yes		no	**MUSCULOSKELETAL**			
ENDOCRINOLOGY				Joint stiffness	yes		no
Excessive thirst	yes		no	Joint pain	yes		no
Cold intolerance	yes		no	Joint swelling	yes		no
Heat intolerance	yes		no	Leg cramps	yes		no
Diabetes	yes		no	Sciatica	yes		no
Hair loss	yes		no	Fracture	yes		no
Goiter	yes		no	**NEUROLOGY**			
Tired/sluggish	yes		no	Headache	yes		no
UROLOGY				Tingling/numbness	yes		no
Difficulty urinating	yes		no	Seizures	yes		no
Frequent urination	yes		no	Dizziness	yes		no
Urinary incontinence	yes		no	Memory loss	yes		no
Recurrent UTI	yes		no	**OPTHALMOLOGY**			
Frequent urination at night	yes		no	Diminished vision	yes		no
Blood in the urine	yes		no	Cataracts	yes		no
				Eye irritation	yes		no

FAMILY HISTORY: (Has anyone in your family ever been treated for any of the following? Please check all that apply.)

	FATHER	MOTHER	AUNT	UNCLE	BROTHER	SISTER	CHILDREN	GRANDPARENT
ANXIETY								
DEPRESSION								
PANIC								
SUICIDAL BEHAVIOR								
PSYCHOSIS								
SUBSTANCE ABUSE								
LOUD SNORING								
DAYTIME SLEEPINESS								
HIGH BLOOD PRESSURE								
STROKE								
HEART DISEASE								

HAVE ANY OF YOUR IMMEDIATE FAMILY MEMBERS (mom, dad, sibling, etc.) EVER TAKEN MEDICATIONS FOR WHAT BRINGS YOU TO US TODAY? IF SO, WHAT MEDICATION AND DID IT WORK WELL FOR THEM?

_____

_____

_____

_____

WHERE WERE YOU BORN?_____

HOW MANY CHILDREN WERE IN YOUR FAMILY?_____WHERE DID YOU RANK IN THE CHILDREN?_____

HOW WOULD YOU DESCRIBE YOUR HOME LIFE AS A CHILD?_____

_____

_____

_____

EDUCATION HISTORY: (High school, college, graduate school, etc. Where did you attend, when did you graduate, and what degrees did you obtain?)_____

_____

_____

_____

JOB HISTORY:

ARE YOU DISABLED?_____ IF SO FOR HOW LONG?_____

ARE YOU RETIRED?_____ IF SO FOR HOW LONG?_____

IF YOU ARE RETIRED, DISABLED, OR UNEMPLOYED: WHAT WAS YOUR LAST JOB AND HOW LONG WERE YOU THERE FOR?_____

_____

CURRENT OCCUPATION:_____

_____

LENGTH OF TIME AT THIS JOB?_____

MARITAL STATUS: (please circle one)

SINGLE☐ MARRIED☐ SEPERATED☐ WIDOWED☐ DIVORCED☐ COHABITING WITH PARTNER☐

PLEASE LIST ANY CURRENT AND PREVIOUS MARRIAGES, WHEN THEY OCCURRED, HOW LONG THEY LASTED, AND WHY IT ENDED?_____

_____

FAMILY COMPOSITION: (Please list all people living in your household)_____

_____

WHAT ACTIVITIES DO YOU ENJOY DOING?_____

_____

_____

RECREATIONAL SUBSTANCES: (Please circle if you do any of the following)

TOBACCO ☐ ALCOHOL ☐ VAPER CIGERETTE ☐ OTHER ☐

IF YOU SMOKE: HOW MANY CIGERETTES A DAY?_____HOW LONG HAVE YOU SMOKED?_____

ARE YOU READY OR THINKING ABOUT QUITTING?_____

IF YOU DRINK: HOW OFTEN DO YOU DRINK?_____

WHAT DO YOU DRINK?_____

HOW MUCH DO YOU DRINK?_____

IF OTHER: PLEASE EXPLAIN_____

_____

_____

SLEEP HISTORY:

DO YOU HAVE ANY PARTICULAR PROBLEMS WITH YOUR SLEEP?_____

_____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM?_____

HAVE YOU EVER HAD A SLEEP STUDY? IF SO, WHEN AND BY WHO?_____

_____

_____

WHEN DO YOU GO TO BED? WEEKDAYS_____WEEKENDS_____

HOW LONG DOES IT TAKE YOU TO FALL ASLEEP?_____

WHAT POSITION DO YOU SLEEP IN?_____ HOW MANY PILLOWS DO YOU USE?_____

DO YOU SNORE? _____ HAS ANYONE SAID YOU STOP BREATHING WHEN YOU SLEEP?_____

HOW MANY TIMES DO YOU AWAKE AT NIGHT?_____ ARE YOU ABLE TO EASILY FALL BACK TO SLEEP?_____

WHAT TIME DO YOU WAKE UP?_____IS IT ON YOUR OWN OR WITH AN ALARM?_____

HOW LONG FROM THE TIME YOU WAKE UP UNTIL YOU GET OUT OF BED?_____

HOW LONG DOES IT TAKE FOR YOU TO FEEL ALERT AND AWAKE?_____

UPON WAKING UP DO YOU HAVE ANY OF THE FOLLOWING?

HEADACHES ☐	DRY MOUTH ☐	FEELING GROGGY ☐	SHORT OF BREATH ☐	HEART PALPATATIONS ☐

HAVE YOU HAD ANY WEIGHT CHANGES IN THE PAST YEAR AND IF SO, PLEASE DESCRIBE?_____

_____

_____

_____

DO YOU DRINK CAFFEINATED BEVERAGES (Coke, tea, coffee, etc.), IF SO HOW MANY A DAY?_____

_____

_____

DO YOU NAP DURING THE DAY? IF SO, ABOUT HOW LONG?_____

DO NAPS MAKE YOU FEEL (please circle one): BETTER ☐ WORSE ☐ NO DIFFERENT ☐

WHAT DO YOU DO DURING THE DAY? (if you work please put the hours and number of day a week you work):_____

_____

_____

DO YOU HAVE CONCERNS ABOUT ANYTHING ELSE?_____

_____

_____

_____

The Epworth Sleepiness Scale (ESS)

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS, IN CONTRAST TO FEELING JUST TIRED? THIS REFERS TO YOUR USUAL WAY OF LIFE IN RECENT TIMES. EVEN IF YOU HAVE NOT DONE SOME OF THESE THINGS RECENTLY TRY TO WORK OUT HOW THEY WOULD HAVE AFFECTED YOU. USE THE FOLLOWING SCALE TO CHOOSE THE MOST APPROPTAITE NUMBER FOR EACH SITUATION:

0 = WOULD NEVER DOSE

1 = SLIGHT CHANCE OF DOZING

2 = MODERATE CHANCE OF DOZING

3 = HIGH CHANCE OF DOZING

SITUATION:	CHANCE OF DOZING (0-3)
SITTING AND READING	
WATCHING TELEVISION	
SITTING INACTIVE IN A PUBLIC PLACE (e.g. theater or meeting)	
AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	
LYING DOWN TO REST IN THE AFTERNOON WHEN CIRCUMSTANCES PERMIT	
SITTING AND TALKING TO SOMEONE	
SITTING QUIETLY AFTER LUNCH WITHOUT ALCOHOL	
IN A CAR (you driving), WHILE STOPPED FOR A FEW MINUTES IN TRAFIC	
TOTAL SCORE:	

NOTES:_____

_____

_____

_____

PHQ-9

NeuroStar®
Advanced Therapy for Mental Health

Patient Health Questionnaire

Patient Name | Date

Over the last two weeks, how often have you been bothered by any of the following problems?
Use ✓ to indicate your answer.

	Not at all		Several days		More than half the days		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 notice. 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		+		+			
						total		

Healthcare Professional:
For interpretation of total please refer to accompanying score card (reverse side)

10. If you have checked off 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 _____

Would you be interested in learning more about a safe, effective, non-drug treatment for depression?

☐ Yes ☐ No