Depression MD Intervention Psychiatry - Medical History

Patient Name: _____ DOB: _____

Current Diagnosis: _____

Current and Past Medication (*please use end dates to signify discontinued medications*)**:**

Medication & Dose *ex. Sertraline 20mg*	**Duration & Frequency** *1 tab, once daily*	**Start Date** *03/20/2021*	**End Date** *09/20/2021*	**Rating Scale, Start/End Score** *Hamilton Depression Scale (30/12)*

For discontinued medication listed above, please explain the reason for discontinuation and maximum dose tolerated

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Medical Comorbidities	Yes	No
Allergies/hay fever		
Angina		
Asthma		
Cardiac pacemaker		
Intracardiac lines		
Diabetes		
Epilepsy		
Fainting spells or syncope		
Head Trauma/concussion with or without LOC		
Heart attacks		
Kidney stones or other renal problems		

Medical Comorbidities	Yes	No
Hypertension		
Metal Implants		
Migraines		
MRI in the past		
Seizures		
Strokes/TIAs		
Syncope		
Thyroid		
TMS in the past		
IV Ketamine/Spravato in the past		

Please identify any other medical comorbidities

Do you clear this patient for the following procedures?

Transcranial Magnetic Stimulation (TMS): [ ] Yes [ ] No

IV Ketamine/Spravato : [ ] Yes [ ] No

_____ _____

Medical Provider Name and Office (printed) **Signature**:

_____ _____ _____

Date **Phone** **Email**

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Depression MD Intervention Psychiatry - Psychiatric History

Patient Name: _____ DOB: _____

Current Diagnosis: _____ Start Date of Current Depressive Episode: _____

Current and Past Psychiatric Medication (*please use end dates to signify discontinued medications*)**:**

Medication & Dose *ex. Sertraline 20mg*	**Duration & Frequency** *1 tab, once daily*	**Start Date** *03/20/2021*	**End Date** *09/20/2021*	**Rating Scale, Start/End Score** *Hamilton Depression Scale (30/12)*

For discontinued medication listed above, please explain the reason for discontinuation and maximum dose tolerated

_____ _____

Psychiatric Provider Name and Office (printed) **Signature**:

_____ _____ _____

Date **Phone** **Email**

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Depression MD Intervention Psychiatry – Therapy History

Patient Name: _____ DOB: _____

Current Diagnosis: _____ Start Date of Current Episode: _____

Psychotherapy History:

Type of Therapy *ex. CBT*	**Duration & Frequency** *12 weeks, once weekly*	**Start Date** *03/20/2021*	**End Date** *09/20/2021*	**Rating Scale, Start/End Score** *Hamilton Depression Scale (30/12)*

For any discontinued, not completed, therapy above, please explain the reason for discontinuation

_____ _____

Psychotherapy Provider Name and Office (printed) **Signature**:

_____ _____ _____

Date **Phone** **Email**

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