PATIENT QUESTIONNAIRE FOR TMS THERAPY

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Please help us decide whether Apollo TMS Therapy is right for you by filling out the following questionnaire. If you have any questions please feel free to ask us at any time.

PERSONAL INFORMATION

Name: .....

Birthday: .....

Address: .....

Phone Number: .....

E-Mail: .....

Insurance Company: .....

Referring Physician: .....

QUESTIONNAIRE

1. Have you been treated with TMS in the past?

☐ No ☐ Yes .....

2. Do you have any metallic objects in your head or anywhere else in your body? These can include aneurysm clips or coils, stents, implanted stimulators, electrodes to monitor your brain activity, ferromagnetic implants in your ears or eyes, bullet fragments, other metal devices or objects implanted in the head, facial tattoos with metal ink or permanent makeup.

☐ No ☐ Yes .....

3. Do you currently take drugs or medication of any kind?

☐ No ☐ Yes .....

4. Have you had an epileptic seizure in the past?

☐ No ☐ Yes .....

5. Has anyone in your immediate family had an epileptic seizure?

☐ No ☐ Yes .....

6. Have you suffered a traumatic brain injury or other serious head injury? This can include vascular, traumatic, tumoral, infectious, or metabolic lesions of the brain.

☐ No ☐ Yes .....

7. Have you suffered a stroke?

☐ No ☐ Yes .....

8. Is pregnancy a possibility?

☐ No ☐ Yes .....

9. Do you have implants or prostheses of any kind?

☐ No ☐ Yes .....

10. Do you carry a pacemaker or implantable cardioverter defibrillators?

☐ No ☐ Yes .....