Dear Patient,

Thank you for contacting Axon-TMS. We look forward to meeting you and discussing your questions and concerns. We recommend that you arrive fifteen minutes prior to your first scheduled appointment time so check-in can be completed prior to the doctor meeting with you.

The forms following are to be completed by you. The following forms are to be completed by you and brought to the appointment or faxed/emailed prior to the appointment:

- Registration form
- Patient questionnaire
- Authorization form for Exchange of Information.
  - Please include a form for each provider (therapist, psychiatrist, etc.) that you would like us to communicate with.
- PHQ-9 Rating Form
- Prior Treatment History

Please be prepared to pay for your appointment at the time of service. We are happy to file with your insurance company if you would like us to do so, and they may reimburse you for a portion of the visit depending on your coverage.

If you cannot keep this appointment, please call the office as soon as possible.

Thank you,

The Axon Team

Registration Form

PATIENT INFORMATION

Patient's Name: ____ Birth Date: ______________
(Last) (First) (Middle Initial)

Home Address: ____
(Street / Box #) (City/State) (Zip)

Home Phone: _____________________________ Cell Phone: ___________________________

Employer: ________________________________ Work Phone: __________________________

Marital Status: ____________________________ Male _____ Female _____

Primary Physician: _______________________________ Phone: ________________________

Primary Physician Address: ____

Source of Referral: ____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____________________________

Home Phone: ________________________

Cell Phone: __________________________

Address (if different from patient's): ____
(Street / Box #) (City/State)

INSURANCE INFORMATION

Primary Ins. Co. Name: ______________________________ Phone: ____________________________

Policy Holder's Name: ________________________________ DOB: ______________________________

Relationship to Patient: ______________________________ EDI / Payer ID: ____________________

Policy Holder's ID#: __________________________________ Group #: __________________________

Claims Address: ____

Patient History Questionnaire

Name____ Birth Date_______________

Purpose of Evaluation

Why are you interested in treatment with TMS?

____

____

Please list prior psychiatric diagnoses:

____

____

Past Medical History

	Yes	**No**
Have you ever been diagnosed with a medical condition? Please list:		
Have you ever been hospitalized? If so, when and for what condition?		
Have you ever had surgery? If so, what for?		
Are you currently taking any medications? If so, please list medication and dosage.		
Do you have any allergies to medications?		

Patients with any type of non-removable metal in their heads (with the exception of braces or dental fillings), should not receive rTMS. Failure to follow this rule could cause the object to heat up, move, or malfunction, and result in serious injury or death.

Possible Contraindications	**Yes**	**No**
Do you have any of the following: Aneurysm clips or coils, cardiac pacemaker, Internal cardioverter defibrillator (ICD), carotid or cerebral stents, vagus nerve stimulator?		
Do you have any of the following: Metallic devices implanted in your head, dental implants, or other metal?		
Have you ever had a complication from an MRI?		
Do you have an electrode to monitor brain activity?		
Do you have any shrapnel or bullet fragments in or near the head?		
Do you have any facial tattoos with metallic or magnetic-sensitive ink?		

Past Mental Health Treatment

Have you ever received counseling or psychotherapy? If so, when and what was the name of the therapist?

____

____

____

Please list any prior mental health treatment programs, including substance abuse treatment, intensive outpatient or partial hospital programs, or psychiatric hospitalizations.

____

____

____

Prior Treatment History

We are happy to provide a consultation for you to discuss available treatment options.

In order for us to properly assess your eligibility, we request a detailed treatment history. This information will be required by your insurance company if seeking authorizations, so please be as accurate as possible. We realize that you might not remember all of the details; consulting others who are familiar with your condition(family members or friends), your prior records, as well as pharmacy refill records can help complete the list.

Please check the medications you have tried and in the comments include dosage and approximate length of treatment and outcome. Please complete this form to the best of your ability. If some details are difficult to recall, give your best estimate.

A. Medication Treatment:

SSRIs (Selective Serotonin Reuptake Inhibitors):	**Dates Taken: (month/year-month/year)**	**Highest Dosage**	**Benefits, Side effects, Reason for discontinuation, etc.**
__Prozac (fluoxetine)			
__Zoloft (sertraline)			
__Paxil (paroxetine)			
__Celexa (citalopram)			
__Lexapro (escitalopram)			
__Luvox (fluvoxamine)			

SNRIs (Selective Serotonin & Norepinephrine Reuptake Inhibitors)	Dates Taken: (month/year-month/year)	Highest Dosage	Side Effects, Reason for Discontinuation, etc.
__Effexor (venlafaxine)			
__Pristiq (desvenlafaxine)			
__Cymbalta (duloxetine)			
__Fetzima (levomilnacipran)			

Atypical Antidepressants	Dates Taken: (month/year-month/year)	Highest Dosage	Side Effects, Reason for Discontinuation, etc.
__Wellbutrin (Bupropion)			
__Remeron (Mirtazapine)			
__Serzone (Nefazadone)			
__Desyrel (Trazodone)			
__Viibryd			
__Trintellix			
__Fetzima			

Tricyclic Antidepressants	Dates Taken: (month/year-month/year)	Highest Dosage	Side Effects, Reason for Discontinuation, etc.
__Elavil (amitriptyline)			
__Tofranil (imipramine)			
__Pamelor (nortriptyline)			
__Norpramin			

(desipramine)			
__Vivactil (protriptyline)			
__Asendin (amoxapine)			
__Sinequan (doxepin)			
__Other: _______________			

MAOIs (Monoamine oxidase inhibitors)	**Dates Taken: (month/year-month/year)**	**Highest Dosage**	**Side Effects, Reason for Discontinuation, etc.**
__Nardil (phenelzine)			
__Parnate			
__Emsam patches			

Antipsychotics	**Dates Taken: (month/year-month/year)**	**Highest Dosage**	**Side Effects, Reason for Discontinuation, etc.**
__Abilify (aripiprazole)			
__Seroquel (quetiapine)			
__Risperdal (risperidone)			
__Zyprexa (Olanzapine)			
__Geodon (Ziprasidone)			
__Saphris (asenapine)			
__Latuda (lurasidone)			
__Invega (paliperidone)			
__Vraylar (cariprazine)			
__Other: ________________			

Mood Stabilizers	**Dates Taken: (month/year-month/year)**	**Highest Dosage**	**Side Effects, Reason for Discontinuation, etc.**
__Lithium			
__Depakote			
__Tegretol (carbamazepine)			
__Trileptal (oxcarbazepine)			
__Lamictal (lamotrigine)			
__Other: ________________			

Augmentation Agents	**Dates Taken: (month/year-month/year)**	**Highest Dosage**	**Side Effects, Reason for Discontinuation, etc.**
__Synthroid, Levoxyl, Cytomel, Armour thyroid, etc			
__Psychostimulants (Ritalin, Adderall, Dexedrine, Vyvanse, Provigil, Nuvigil)			
__Buspar (buspirone)			
__Deplin (L-methylfolate)			
__Other: _________________			

Other Treatments	Dates attended (Month/year-month/year)	Provider Name	Efficacy and Reason for Discontinuation
__Supportive therapy			
__Cognitive Behavioral Therapy			
__DBT			
__EMDR			
__Other (please specify):___________			
__Electroconvulsive Therapy (ECT, Shock Therapy)			
__Transcranial Magnetic Stimulation (TMS)			
__Psychiatric Admissions or Partial Hospitalization Treatments			
Ketamine Infusions			
Spravato (esketamine)			

For office use only:

☐ I have reviewed the above treatment history with the patient.

_______________________________ _______________________________

Signature Date Reviewed

Authorization for Exchange of Information

Name: ____Date of Birth____/____/____

Address:____SS#:____/____/____

I hereby authorize Axon Health Associates and Axon TMS, LLC

[ ] to release [ ] to obtain

Records to/from:

____

Name Company

____

Address Phone# Fax#

I request the following information to be released regarding myself and/or my child:

[ ] Initial Assessment and Treatment Plan
[ ] Progress Notes
[ ] Psychological Evaluation
[ ] Psychiatric Evaluation
[ ] Diagnosis [ ] Discharge Summary
[ ] Other: [ ] Verbal [ ] Written

Indicate specific information to be EXCLUDED from this authorization (check all that apply):

[ ]Drug and Alcohol Records [ ] HIV/AIDS Records [ ] Infectious Disease records

The purpose for use or disclosure of information:

[ ] Continuity of Care
[ ] Coordination of Services
[ ] Other: please provide a specific description of the purpose /use for disclosure:

____

I understand that my records are protected under the Federal Confidentiality Regulation (42 CFR Part 2) and cannot be released or re-released without my written consent unless otherwise provided for in the regulation. **I understand that these records may include information regarding treatment and related services for alcohol and/or substance abuse, communicable disease documentation, human immunodeficiency virus (HIV) or for mental health treatment or counseling.** I also understand that I may revoke this consent at any time, except to the extent that release has already occurred.

This consent is valid for 12 months from the date signed by the patient or authorized party below, unless revoked by me prior to that date, upon the completion or satisfaction of the event or conditions specified; whichever comes first. A copy of this authorization shall be valid as the original.

I understand that the following fees may apply:
Record Retrieval $25.00
Charge $.25 (per page over 10 pages)
1-2 Day Service $10.00

Patient Signature: ____________________________________Date:____________

____________________________________ ________________________________

Patient Printed Name Witness Signature

9245 North Meridian Street, Suite 225 Indianapolis, Indiana 46260
Phone (317) 899 9362

PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)

Over the last 2 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 have noticed? Or the opposite — being so fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING __*0*__ + ____ + ____ +____
=TotalScore: _____

If you 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**

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

***If your score on the Patient Health Questionnaire-9 (PHQ-9) for question 9 was a “1, 2 or 3”, please complete the following assessment.   If your score was a 0, you may skip this section.

Suicide Risk Assessment

1. In the past few weeks, have you wished you were dead? ☐ Yes ☐ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
3. In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
4. Have you ever tried to kill yourself? ☐ Yes ☐ No

   If yes, how?

   ____

   ____

   ____

   When?

   ____

   ____

   ____

5. Are you having thoughts of killing yourself right now? ☐ Yes ☐ No