15 S Grady Way STE 625
Renton, WA 98057
P: 425-919-6826
office@eastsidetmswellness.com

TMS Intake Packet

TMS, or Transcranial Magnetic Stimulation, is FDA approved for the treatment of adults aged 22-70 suffering from moderate to severe major depressive disorder that has not adequately responded to medica-tions and therapy. If you believe you meet these criteria and would benefit from TMS therapy, call Eastside TMS and Wellness Center, LLC to confirm that we work with your insurance carrier first. Then please fill out the forms below and return them to us. You may send them to us via fax to **(425) 523-1061** or email them to **office@eastsidetmswellness.com.**

Step 1

- **Fill out the demographic information**
- **Make sure to include all insurance information**

Step 2

- **Answer a few questions about potential interactions**
- **Compile a list of all psychiatric medications tried in your lifetime**
- **Include as much information as possible (key to getting insurances to cover TMS)**
- **Provide information regarding therapy**

Step 3

- **Authorize Eastside TMS and Wellness Center, LLC to obtain your medical history**
- **This helps the provider determine if TMS is right for you**

Step 4

- **Complete two questionnaires to help measure your current state of depression**
- **We will use this as a tool during treatment to track your progress**

Last Step

- **Give us two business days to investigate your coverage. We will reach out to you to go over your options for TMS treatment**

The next page is the beginning of Step 1. Please make sure all the information provided is accurate and truthful to the best of your knowledge.

Step 1

Patient Information	
Full Name	
Date of Birth	
Gender	
Address	
City	
State	
Zip	
Phone (cell preferred)	
E-Mail	
Today's Date	

Primary Insurance Information	
Insurance Provider	
Name of Policy Holder	
Member ID Number	
Group Number	
Relationship to Policy Holder	
Phone Number (mental health benefits)	
Employer of Policy Holder	

Secondary Insurance Information	
Insurance Provider	
Name of Policy Holder	
Member ID Number	
Group Number	
Relationship to Policy Holder	
Phone Number (mental health benefits)	
Employer of Policy Holder	

EAST SIDE TMS AND WELLNESS CENTER

Step 2

Question	Yes	No
Do you have any non-removable metal objects in your head or neck? - Examples: Cochlear implants, deep brain stimulators, implanted electrodes, vagus nerve stimulators, aneurysm clips or coils, stents, CSF shunts, staples, metallic sutures, bullet fragments.	☐	☐
Do you have any implanted medical devices? - Examples: Pacemakers or defibrillators	☐	☐
Do you have any implanted medical devices?	☐	☐
Do you have any history of seizures?	☐	☐
Do you have any history of stroke or head injury?	☐	☐

List all medications you have tried or currently take, related to treatment of your depression. Most insurance companies require two to four failed medications to approve TMS treatments.

Medication	Class	Dose/ Frequency	Length of trial	When	Why didn't it work (side effects, burn-out, etc.)

Current Therapist	
Name	
Phone	
How long	

Previous Therapist	
Name	
Phone	
How long	

Step 3

Authorization to release information

Patient Information

Full Name	
Date of Birth	
Gender	
Address	
Phone	

Provider Information

Provider	
Clinic	
Email	
Address	
Phone/Fax	

I hereby authorize the provider named above to release the following information to Eastside TMS and Wellness Center, LLC for the purpose of determining whether Transcranial Magnetic Stimulation (TMS) therapy is an appropriate and medically necessary treatment for me:

- ☐ Psychiatric diagnoses
- ☐ Intake notes and most recent visit notes OR clinical summary
- ☐ Psychiatric medication history including dosage, dates of therapy, and outcomes
- ☐ Current medication list
- ☐ Recent diagnostic measurement scores (e.g. PHQ-9)
- ☐ Psychotherapy history (dates, duration, frequency, outcomes)
- ☐ ECT treatment dates and outcomes, if applicable

I understand this information may be re-disclosed by Eastside TMS and Wellness Center, LLC, for the purpose of requesting authorization from my insurance plan for TMS therapy. This authorization may be revoked at any time by my written statement except to the extent that action has already been taken on it. It is automatically revoked 30 days after the termination of the therapeutic relationship or under the following conditions (specify below):

Patient Name	Date	Staff Name	Date

Step 4

PHQ-9 Depression Rating Scale

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

- PHQ-9 total score ☐

Check your choice for each question. Don't worry about scoring, we will handle that.

Step 4 continued

GAD—7

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it's hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐
Add the score for each column	+	+	+	

Total Score *(add your column scores)* =

That's it, you are finished. You can now send your completed packet via Email to **office@eastsidetmswellness.com**, or fax it to **425-523-1061**. Please allow two to three business days for us to investigate your coverage and get back to you.