TMS NEW PATIENT QUESTIONNAIRE

Walter G. Griffith, Jr., MD, PA and Kaitlan Griffith, PA

5565 Dr. MLK Jr. St. North (9th Street N)
St. Petersburg, FL 33703
Tel# 727-577-1203 Fax# 727-577-0983

GENERAL INFORMATION

NAME_____DATE: _____

STREET_____

CITY_____STATE_____ ZIP_____

TEL#'s: (Home)_____(Cell)_____(Work): _____

Date of Birth_____ Age_____ Religion_____

Email Address _____

JOB TITLE / EMPLOYER_____#Yrs _____

Height:_____Weight:_____(lbs.) SS#_____INSURANCE_____

# of Children & Ages_____

FAMILY DOCTOR_____ DRUG ALLERGIES_____

CURRENT LIFE SITUATION

- **What are you seeking help for during your appointment?**

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

HOSPITALIZATIONS / SURGERIES

YEAR	HOSPITAL / LOCATION	NATURE OF ILLNESS

CURRENT MEDICATION INFORMATION

MEDICATION	Mg/Day	REASON ON MEDICATION

Are you NOW having any of the following problems?		Have you had any of these medical problems?	
□ Significant Weight gain	□ Significant Weight loss	□ Hypertension	□ Diabetes
□ Loss of consciousness	□ Eye pain, double vision	□ Stroke	□ Heart Attacks
□ Hearing loss, ringing	□ Dizziness	□ Thyroid problem	□ Chronic Headaches
□ Lightheaded standing	□ Shortness of breath	□ Arthritis	□ Ulcer
□ Chest pain	□ Ankle swelling	□ Kidney Stone	□ Seizures
□ Bloody or pink urine	□ Severe abdominal pain	□ Cancer-type_____	□ Other_____
□ Frequent heartburn	□ Tar-colored stools		

Does anyone in your family have a history of the following?	Which family member? (**please specify maternal or paternal)
□ Cancer – which type _____	_____
□ Stroke	_____
□ Hypertension (high blood pressure)	_____
□ Diabetes	_____

Additions/Comments_____

_____

_____

PAST PSYCHIATRIC HISTORY

Please complete the following table regarding HISTORY of PSYCHIATRIC ILLNESS for YOURSELF and BLOOD RELATIVES (use checkmarks where applicable)

PSYCHIATRIC HISTORY	SELF	Father	Mother	Grand-parents	Brother /sister	Kids	Aunt/ Uncle	Cousin
Major Depression								
Anxiety Disorder								
Bipolar/Manic-Depression								
ADHD—Attention Deficit								
Schizophrenia								
Schizoaffective Disorder								
Alcohol or Drug Abuse								
Anorexia/Bulimia/Eating Disorder								
Suicide Attempt								
Psychiatric Hospitalization								
Under the care of Psychiatrist								
Treated with Psychiatric Medication								
Saw a Therapist / Counselor								
Probable disorder but never treated								
Criminal History								
Other								

Other Comments_____

_____

Your Recreational Substance Use Pattern

Name of Substance	Never Used	Past Use Only	Current Use	# Yrs of Use	Frequency or Amount Used (eg, drinks/day, joints/week)
Tobacco					
Caffeinated Drinks					
Alcohol					
Marijuana					
Pain Pills					
Benzodiazepines					
Cocaine					
Crack					
Acid/Mushrooms					
Ecstasy					
Speed					
Crystal Meth					
PCP					
Barbiturates					
Heroin					
Other:					

Your Psychiatric Medication History

(please complete the table below for medications you have been treated with or have tried)

Brand Name	Generic Name	Dose	Taken How long	Very Helpful	Mildly Helpful	Not Helpful	Side Effects
Prozac	**Fluoxetine**						
Paxil	**Paroxetine**						
Zoloft	**Sertraline**						
Luvox	**Fluvoxamine**						
Celexa	**Citalopram**						
Lexapro	**Escitalopram**						
Effexor	**Venlafaxine**						
Cymbalta	**Duloxetine**						
Pristiq	**Desmethylvenlafaxine**						
Remeron	**Mirtazapine**						
Fetzima	**Levomilnacipran**						
Viibryd	**Vilazodone**						
Wellbutrin	**Bupropion**						
Trintellix	**Vortioxetine**						
Elavil	**Amitriptyline**						
Tofranil	**Imipramine**						
Sinequan	**Doxepin**						
Pamelor	**Nortriptyline**						
Norpramin	**Desipramine**						
Desyrel	**Trazodone**						
Lithobid/Eskalith	**Lithium**						
Depakote	**Divalproate**						
Lamictal	**Lamotrigine**						
Trileptal	**Oxycarbazepine**						
Tegretol	**Carbamazepine**						
Neurontin	**Gabapentin**						
Latuda	**Lurasidone**						
Risperdal	**Risperidone**						
Zyprexa	**Olanzapine**						
Seroquel	**Quetiapine**						
Geodon	**Ziprazidone**						
Abilify	**Aripiprazole**						
Symbyax	**Olanzapine/prozac**						
Haldol	**Haloperidol**						
Saphris	**Asenapine**						
Trilafon	**Perphenazine**						
Xanax	**Alprazolam**						
Ativan	**Lorazepam**						
Klonopin	**Clonazepam**						
Valium	**Diazepam**						
Librium	**Clordiazepoxide**						
Restoril	**Temazepam**						
Halcion	**Triazolam**						
Ambien CR	**Zolpidem**						
Lunesta	**Ezoplicone**						
Sonata	**Zaleplon**						
Ritalin	**Methylphenidate**						
Concerta	**Methylphenidate**						
Adderall	**Dexamphetamine**						
Straterra	**Atomoxetine**						
Vynvase	**Lisdexamfetamine**						
Vraylar	**Cariprazine**						
Provigil	**Modafinil**						

Other Comments_____

_____

Patient Signature_____ **Date**_____

Informed Consent for Treatment

Walter G. Griffith, Jr., MD, P.A. and Kaitlan Griffith, PA
5565 Dr. MLK Jr. St. North (9th Street N)
St. Petersburg, FL 33703-1203
Tel# 727-577-1203 Fax# 727-577-0983

I, _____, hereby voluntarily request diagnostic evaluation and medical treatment, which may include individual family, couples, and group therapies, medication management, consultation, education, and referral to other community resources, provided by Walter G. Griffith, Jr., MD.

I understand

- The purpose of this treatment
- Possible alternative treatments exist
- Treatment includes potential risks and benefits
- No diagnostic or therapeutic guarantees have been made
- My participation in treatment is voluntary and I may stop at any time

My signature below certifies my understanding and acceptance of the intent of this informed consent.

Patient Signature_____Date _____

Guardian/Power of Attorney_____ Date _____

Witness_____Date_____

Notice of Privacy Practices

Walter G. Griffith, Jr., MD, P.A. and Kaitlan Griffith PA
5565 Dr. MLK Jr. St. North (9th Street N)
St. Petersburg, FL 33703-1203
Tel# 727-577-1203 Fax# 727-577-0983

This Notice describes how medical information about you may be used to disclosed, and how you may have access to this information
(PLEASE REVIEW CAREFULLY)

Introduction - The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, remain properly confidential. This act gives you, the patient, rights to understand and control how your health information is used. As required by HIPAA, we have prepared this explanation of the privacy of your health information and how we may use and disclose your health information.

Three ways we may use and disclose health information about you:

- Treatment means providing, coordinating, or managing health care and related services by one or more providers, e.g., performing an evaluation or follow-up appointment, or phoning your prescription refill to the pharmacy.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilizations review, e.g., sending a bill to your insurance company for an appointment.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment activities, auditing functions, cost-management analysis, and customer service, e.g., Staff training meetings.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you revoke consent for the above activities, we may not be permitted to use or disclose information for the purpose of treatment, payment, or health care operations, and we may therefore choose to discontinue providing you health care treatment and services.

Special situations in which we may disclose health information about you without your permission: To avert serious threat or harm to your health or safety, to the public, or to another individual; as required by federal, state or local laws; to an organ or tissue bank if you are an organ donor; by command of military command or other government authorities if you are or were a member of the armed forces, national security or intelligence communities; for worker's compensation if you are seeking benefits for work-related injuries or illness; for public health risks to prevent or control disease, injury or disability, or to report births, deaths, suspected abuse or neglect, non-accidental injuries, reactions to medications or problems with products; to federal, state, and local health oversight agencies for audits, inspections, investigations, or licensing purposes; to a court or administrative order if you are involved in a dispute or lawsuit; to a law enforcement official in response to a court order, subpoena, warrant, summons subject to applicable requirements; de-identified health information (i.e., references to individually identifiable information removed); to coroners, medical examiners, and funeral directors to identify a deceased person or to determine cause of death.

Other uses and disclosures of health information require written authorization: Any other uses or disclosures, of your health information will be made only with your written authorization. You may revoke such authorization in writing at any time and we are required to abide by that written request except for previous disclosures made with your permission.

You have the following rights, which you can exercise by presenting a written request:

- To request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- To reasonable requests to receive confidential communications of health information involving alternative means or locations.
- To inspect and copy, upon submission of a written request, your protected health information (we may charge a fee for associated costs to supervision, copying, or handling).
- To amend your protected health information (we may charge a fee for associated costs to review and amend the record).
- To receive an accounting of disclosures of protected health information.
- To obtain a paper copy of this Notice of Privacy Practices upon request.

Miscellaneous - We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain or receive in the future. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. If you believe your privacy rights have been violated, you may file a complaint with our office (at the above address) to Walter Griffith, MD, the Privacy Officer, or with the Secretary of the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Walter G. Griffith, Jr., MD, P.A. and Kaitlan Griffith, PA

General Psychiatry—Board Certified

5565 Dr. MLK Jr. St. North (9th Street N)

St. Petersburg, FL 33703-1203

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have the certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly**
- **Obtain payment from third- party payors**
- **Conduct normal healthcare operations such as quality assessments and physician certifications**

I have received, read, and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Walter G. Griffith, Jr. MD, PA, has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain patient's signature on this *Notice of Privacy Practices*, but was unable to do so as documented below:

Date: _____ Initials: _____ Reasons: _____

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HIPAA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly**
- **Obtain payment from third-party payors**
- **Conduct normal healthcare operations such as quality assessments and physician certifications**

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Walter G. Griffith, Jr., MD, PA, has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used to or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Patient Consent for a Medical Procedure- NeuroStar TMS Therapy

Walter G. Griffith Jr., MD, PA and Kaitlan Griffith, PA

This is a patient consent for a medical procedure called NeuroStar TMS Therapy. This consent form outlined the treatment that your doctor has prescribed for you, the risks of this treatment, the potential benefits of this treatment to you and any alternative treatments that are available for you if you decide not be treated with NeuroStar TMS Therapy.

The information contained in this consent form is also described in the Depression Patient's Manual for Transcranial Magnetic Stimulations with the NeuroStar TMS Therapy System which is available from your doctor. Not all information in the Manual is stated here, so you should read the Patient Manual and discuss any questions that you have with your doctor. Once you have reviewed the manual and this consent form, be sure to ask you doctor any questions that you may have about NeuroStar TMS Therapy.

Dr. Griffith has explained the following information to me:

a) TMS stands for "Transcranial Magnetic Stimulation." NeuroStar TMS Therapy is s medical procedure. A TMS treatment session is conducted using a device called the NeuroStar TMS Therapy System, which provides electrical energy to a "treatment coil" or magnet that delivers pulsed magnetic fields. These magnetic fields are the same type and strength as those used in magnetic resonance imaging (MRI) machines.

b) NeuroStar TMS Therapy is a safe and effective treatment for patients with depression who have not benefitted from antidepressant medications.

c) Specially, NeuroStar TMS Therapy have been shown to relieve depression symptoms in adult patients who have been treated with prior antidepressant medication but did not get better.

d) The safety and efficacy of NeuroStar TMS Therapy has not been established with patients who did not take any antidepressants during this current period of depression.

e) During a TMS treatment session, the doctor or a member of their staff will place the magnetic coil gently against my scalp on the left front region of my head. The magnetic fields that are produced by the magnetic coil are pointed at a region of the brain that scientist think may be responsible for causing depression.

f) To administer the treatment, the doctor or a member of their staff will first position my head in the head support system. Next, the magnetic coil will be placed on the left side of my head, and I will hear a clicking sound and feel a tapping sensation on my scalp. The doctor will then adjust the NeuroStar TMS Therapy system so that the device will give just enough energy to send electromagnetic pulses into the brain so that my right-hand twitches. The amount of energy required to make my hand twitch is call the "motor threshold." Everyone has a different motor threshold and the treatments are given at an energy level that is just above my individual motor threshold. How often my motor threshold will be re-evaluated will be determined by my doctor.

g) Once motor threshold is determined, the magnetic coil will be moved, and I will receive the treatment as a series of "pulses" that last about 4 seconds, with a "rest" of about 11-26 seconds between each series. Treatment is to the left front side of my head and will take about 18-40 minutes. I understand that this treatment does not involve any anesthesia or sedation and that I will remain awake and alert during the

treatment. I will likely receive these treatments 5 times a week for 4 to 6 weeks (20 to 30 treatments). I will be evaluated by the doctor three (3) times during this treatment course. The treatment is designed to relieve my current symptoms of depression.

h) During the treatment, I may experience tapping or painful sensations at the treatment site while the magnetic coil is turned on. These types of sensations were reported by about one third of the patients who participated in the research studies. I understand that I should inform the doctor or his /her staff if this occurs. The doctor may then adjust the dose or make changes to where the coil is placed in order to help the procedure more comfortable to me. I also understand that headaches were reported in half of the patients that who participated in the clinical trial for the NeuroStar device. I understand that both discomfort and headaches got better over time in the research studies and that I may take common other-the- counter pain medications such as acetaminophen if a headache occurs.

i) The following risks are also involved with this treatment:

The NeuroStar TMS Therapy System should not be used by anyone who has magnetic sensitive metal in their head or within 12 inches of the NeuroStar magnetic coil that cannot be removed. Failure to follow this restriction could result in serious injury or death. Objects that may have this kind of metal includes:

- 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

j) The NeuroStar TMS System should be used with caution in patients who have pacemakers or implantable cardioverter defibrillators (ICDs or are using wearable cardioverter defibrillators (WCD). Failure to follow this restriction could result in sericeous injury or death.

k) Neuro Star TMS System is not effective for all patients with depression. Any signs or symptoms of worsening depression should be reported immediately to your doctor. You may want to ask a family member or caregiver to monitor your symptoms to help you spot any signs of worsening depression.

l) Seizures (sometime called convulsions or fits) have been reported with the used of TMS devices. However, no seizures were observed with use of the NeuroStar TMS Therapy System in over 10,000 patient treatment sessions in trials conducted prior to FDA clearance of the NeuroStar TMS System. Since the introduction of the NeuroStar TMS System into clinical practice, seizures have been rarely reported. The estimated risk of seizure under ordinary clinical use is approximately 1 in 30,000 treatments or 1 in 1000 patients.

m) Because the NeuroStar TMS Therapy system produces a loud click with each magnetic pulse, I understand that I must wear earplugs or similar hearing protection devices with a range of 30dB or higher of noise reduction during treatment.

n) I understand that most patients who benefit from NeuroStar TMS Therapy experience results by the fourth week of treatment. Some patients may experience results in less time while other may take longer.

o) I understand that I may discontinue treatment at any time.

I have read the information contained in this Medical Procedure Consent Form about Neuro Star TMS Therapy and its potential risks. I have discussed it will Dr. Griffith who has answered all of my questions. I understand there are other treatment options for my depression available to me and this has also been discussed with me.

I therefore permit Dr. Griffith and his/her staff to administer this treatment to me.

Patient Name: _____

Patient Signature: _____

Witness: _____

Date: _____