PREMIER PSYCHOLOGICAL
COUNSELING & CONSULTING, PC
PREMIER TMS
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History and Presenting Problem

Name_____ **Date of Birth**_____ **Sex** _____**Today's Date** _____

For what reason(s) are you seeking services from our office?

What is the duration of these symptoms? (How long? Has the intensity varied?)

Have you seen a counselor or psychologist before? YES If yes, please complete the questions below

Name of Dr/Therapists	Appointment Frequency	Start and Stop Date/Duration	Reason(s) you were being seen.	Outcome/ Did it help?

DEVELOPMENT and EDUCATION

When your mother was pregnant with you, were there any complications during the pregnancy or birth?
If yes, please describe.

Do you have any history of any of the following conditions? (please check all that apply)

☐ Head Injury ☐ High Fever ☐ Chronic Medical Illness ☐ Prenatal exposure to toxins (drugs &/or alcohol)

Please give additional information related to the ones you checked.

Please select the highest level of education you have completed:

How would you describe your educational experience? (please check all that apply)

☐ Enjoyable/I love to learn ☐ Very stressful ☐ Didn't have any friends ☐ I was always bored

☐ I struggled learning ☐ I learned best in "hands-on" classes ☐ I only enjoyed the social part of school

Have you had any legal issues specifically related to your conduct or behavior? (past or present)
If yes, please explain

MEDICAL and PSYCHIATRIC

Primary Care Physician:_____Office Phone Number_____
Current health conditions:

Previous Medical or Psychiatric Diagnoses:

Select the words that best apply:

Handedness _____ Appetite_____ Weight _____ Thought Processing _____

Predominant Mood (Pick all that apply)
☐ Anxious ☐ Depressed ☐ Happy ☐ Sad
☐ Fearful ☐ Manic ☐ Just so-so ☐ Flat
☐ Other _____

In the past six months, have you experienced: (Pick all that apply)
☐ Moderate Exercise ☐ Inability to have fun ☐ Pleasurable Activities
☐ Stable, enjoyable sex life ☐ Diminished interest in activities ☐ Pre-occupation with pleasurable activities

SLEEP: Number of hours/night:_____ Quality: _____ Waking up: _____

Frequent experience of: ☐ nightmares ☐ night terrors ☐ recurrent dreams

How would you rate your sleep disturbance?

Current Symptoms
Rate the items with which you are currently having problems. Select the number that best indicates the severity of the problem.

0=None 1=Minor 2=Moderate 3=Significant 4=Serious

Thoughts of Self-harm		**Anxiety-Worry**		**Anxiety-Fear**	
Anxiety-Panic		**Anxiety-Phobia**		**Feelings of Depression**	
Feelings of Sadness		**Thoughts of Death**		**Thoughts of Suicide**	
Mood Swings		**Grief over a major loss**		**Grief over the death of a loved one**	
Abuse-Emotional		**Abuse-Physical**		**Abuse-Domestic**	
Abuse-Ritual		**Sexual Abuse-Rape**		**Sexual Abuse-Incest**	
Feelings of Despair		**Memory-Forgetfulness**		**Memory-Changes**	
Marriage Problems		**Relationship problems with children**		**Problems with Parents**	
Problems with Family		**Problems with Work/School**		**Legal problems**	
Problems with Alcohol		**Problems with Drugs**		**Problems with Smoking**	
Problems with other substances		**Feelings of Hopelessness**		**Feelings of Helplessness**	
Sexual concerns		**Sexual problems**			

MEDICATION REPORT

Current Medications

Name	Dosage	How often?	When started?	Reason for taking	Response/Side Effects
		1x daily	less than one month		
		1x daily	less than one month		
		1x daily	less than one month		
		1x daily	less than one month		
		1x daily	less than one month		

Current Supplements and/or Vitamins (including over the counter)

Name	Dosage	How often?	When started?	Reason for taking	Response/Side Effects
		1x daily	less than one month		
		1x daily	less than one month		
		1x daily	less than one month		
		1x daily	less than one month		

Past Medications

It is very helpful to know of past medications taken and how they affected you.
(If you don't remember exact information, please provide the best information you can.)

Medication Type:- SSRI's

Name	Dosage	For how long?	Last used?	Effective?	Side Effect(s)
Celexa (citalopram)		less than one month	less than one month ago	No	
Lexapro (escitalopram)		less than one month	less than one month ago	No	
Luvox (fluvoxamine)		less than one month	less than one month ago	No	
Paxil, Paxil CR, (paroxetine, paroxetine CR)		less than one month	less than one month ago	No	
Prozac (fluoxetine)		less than one month	less than one month ago	No	
Trintellix (vortioxetine)		less than one month	less than one month ago	No	
Viibryd (vilazodone)		less than one month	less than one month ago	No	
Zoloft (sertraline)		less than one month	less than one month ago	No	

Medication Type:- SNRI's

Name	Dosage	For how long?	Last used?	Effective?	Side Effect(s)
Cymbalta (duloxetine)		1-3 months	less than a month ago	No	
Effexor (incl. IR & XR) (venlafaxine)		1-3 months	less than a month ago	No	
Pristiq (desvenlafaxine)		1-3 months	less than a month ago	No	
Strattera (atomoxetine)		1-3 months	less than a month ago	No	

Medication Type:- Augmented

Name	Dosage	For how long?	Last used?	Effective?	Side Effect(s)
Abilify (aripiprazole)		1-3 months	less than a month ago	No	
Depakote (divalproex)		1-3 months	less than a month ago	No	
Geodon (ziprasidone)		1-3 months	less than a month ago	No	
Invega (paliperidone)		1-3 months	less than a month ago	No	
Neurontin (gabapentin)		1-3 months	less than a month ago	No	
Risperdal (risperidone)		1-3 months	less than a month ago	No	
Saphris (asenapine)		1-3 months	less than a month ago	No	
Seroquel (quetiapine)		1-3 months	less than a month ago	No	
Zyprexa (olanzapine)		1-3 months	less than a month ago	No	

MEDICATION REPORT-Cont.

Medication Type:- Stimulants

Name	Dosage	For how long?	Last used?	Effective?	Side Effect(s)
Adderall (d/l amphetamine)		less than one month	more than a year ago	No	
Dexadrine (d-amphetamine)		less than one month	more than a year ago	No	
Intuniv/Tunix (guanfacine)		less than one month	more than a year ago	No	
Ritalin (methylphenidate)		less than one month	more than a year ago	No	

Medication Type:- TCA/Tetracyclic

Name	Dosage	For how long?	Last used?	Effective?	Side Effect(s)
Anafranil (clomipramine)		less than one month	more than a year ago	No	
Elavil, Endep (amitriptyline)		less than one month	more than a year ago	No	
Ludiomil (maprotilene)		less than one month	more than a year ago	No	
Merital (nomifensine)		less than one month	more than a year ago	No	
Norpramin, Pertofrane (desipramine)		less than one month	more than a year ago	No	
Pamelor, Aventyl (nortriptyline)		less than one month	more than a year ago	No	
Sinequan (doxepin)		less than one month	more than a year ago	No	
Surmontil (trimipramine)		less than one month	more than a year ago	No	
Tofranil (imipramine)		less than one month	more than a year ago	No	
Vivactil (protriptyline)		less than one month	more than a year ago	No	

Medication Type:- MAOI

Name	Dosage	For how long?	Last used?	Effective?	Side Effect(s)
Eldepryl (Selegine)		less than one month	more than a year ago	No	
Ensam (Selegine patch)		less than one month	more than a year ago	No	
Nardil (phenelzine)		less than one month	more than a year ago	No	
Marplan (isocarboxazid)		less than one month	more than a year ago	No	
Parnate (tranylcypromine)		less than one month	more than a year ago	No	

Medication Type:- Hormone Replacement

Name	Dosage	For how long?	Last used?	Effective?	Side Effect(s)
Estrogen Hormone		less than one month	more than a year ago	No	
Progesterone Hormone		less than one month	more than a year ago	No	
Testosterone Hormone		less than one month	more than a year ago	No	
Thyroid Hormone		less than one month	more than a year ago	No	

Medication Type:- Other

Name	Dosage	For how long?	Last used?	Effective?	Side Effect(s)
Ativan (lorazepam)		less than one month	more than a year ago	No	
Buspar (buspirone)		less than one month	more than a year ago	No	
Catapres (clonidine)		less than one month	more than a year ago	No	
Desyrel (trazodone)		less than one month	more than a year ago	No	
Lithium (Carbonate)		less than one month	more than a year ago	No	
Mellaril (thioridazie)		less than one month	more than a year ago	No	
Minipress (prazocin)		less than one month	more than a year ago	No	
Remeron (mirtazapine)		less than one month	more than a year ago	No	
Serzone (nefazodone)		less than one month	more than a year ago	No	
Valium (diazepam)		less than one month	more than a year ago	No	
Wellbutrin (buproprion)		less than one month	more than a year ago	No	
VNS		less than one month	more than a year ago	No	
Light Box		less than one month	more than a year ago	No	

FAMILY MEDICAL HISTORY

Did your parent(s) have a history of alcohol or drug abuse? If yes, please explain below.

Has anyone in your family been diagnosed with or treated for:

Condition	What relative(s)?	Condition	What relative(s)?
☐ Anxiety		☐ Depression	
☐ Anger		☐ Schizophrenia	
☐ Bipolar Disorder		☐ Post-traumatic Stress	

PERSONAL HISTORY

Do you have a history of Self-Harm? No
If yes, please explain

Do you have a history of physical, sexual, or emotional abuse? No
If yes, please explain

Do you have a history of alcohol and drug use? No
If yes, please explain

Have you been hospitalized for psychiatric reasons? No
If yes, please explain

PERSONAL INTERESTS

List hobbies and leisure interests

List individual strengths/positives

Who do you have for a personal support system?

This form was completed by:_____

Relationship to patient:___ Self _____

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