

TMS Prescreen Questionnaire

Basic Information

1. **Full Name**
☐ *Short answer*
 2. **Phone Number**
☐ *Short answer*
 3. **Email Address**
☐ *Short answer*
 4. **Preferred Method of Contact**
☐ Phone ☐ Email ☐ Text
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Symptoms & Diagnosis

5. **Have you been diagnosed with depression or another mental health condition?**
☐ Yes
☐ No
☐ Not sure
 6. **Which symptoms are you currently experiencing?** (*Select all that apply*)
☐ Persistent low mood
☐ Loss of interest or pleasure
☐ Low energy or fatigue
☐ Sleep problems
☐ Anxiety
☐ Difficulty concentrating
☐ Suicidal thoughts
 7. **How long have you been experiencing these symptoms?**
☐ Less than 6 months
☐ 6–12 months
☐ 1–5 years
☐ More than 5 years
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Treatment History

8. **Have you tried antidepressant or psychiatric medications in the past?**
☐ Yes

- ☐ No
☐ Currently taking medication
9. **Have you participated in psychotherapy (talk therapy)?**
☐ Yes
☐ No
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TMS Safety Screening (Required)

10. **Have you ever had a seizure or epilepsy?**
☐ Yes ☐ No
11. **Do you have any metal in your head or neck (excluding dental fillings)?**
☐ Yes ☐ No
12. **Do you have an implanted medical device (pacemaker, cochlear implant, neurostimulator, aneurysm clip)?**
☐ Yes ☐ No
13. **Have you had a significant head injury, brain surgery, or stroke?**
☐ Yes ☐ No
14. **Are you currently pregnant or planning to become pregnant?**
☐ Yes ☐ No
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Insurance

15. **Which health insurance plan do you currently have?**
- ☐ Short answer
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Final Acknowledgment

16. ☐ I understand this is a preliminary screening and does not guarantee eligibility for TMS treatment.
17. **Electronic Signature (Type Full Name)**
☐ *Short answer*
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Thank you for completing the TMS prescreen. Our team will review your responses and contact you shortly to discuss next steps and schedule a consultation if appropriate.

