

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

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

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

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

Insurance

15. **Which health insurance plan do you currently have?**

- Short answer

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*

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.

