TMS NEW PATIENT INFORMATION

Patient's Legal Name
(Last, First, Middle) _____. **SS#** _____.

DOB _____. **Sex**_____. **Marital Status** _____.

Address_____ **City** _____. **State**_____. **Zip** _____.

Home ( ) _____. **Work ( )** _____. **Cell ( )**_____.

Your Email Address:_____

Treating Physician_____.

Address_____. **City** _____. **State**_____. **Zip** _____.

Tel ( ) _____. **Fax ( )**_____. **Email** _____.

CLINICAL HISTORY - If you answer yes to any of the questions below, please describe

Yes	**No**	Do you have a cardiac pacemaker?
Yes	**No**	Do you have an aneurysm clip?
Yes	**No**	Do you have a vagal nerve stimulator?
Yes	**No**	Do you have a cochlear implant?
Yes	**No**	Do you have any other implanted device?
Yes	**No**	Do you have any metallic objects in your body? If yes, describe
Yes	**No**	Have you every had any metallic foreign body in your eye? If yes, describe
Yes	**No**	Do you have cancer?
Yes	**No**	Do you have headaches?
Yes	**No**	Do you have anxiety?
Yes	**No**	Have you every had a seizure?
Yes	**No**	Have you ever suffered a stroke?
Yes	**No**	Do you have any cardiac disease?
Yes	**No**	Do you have any infectious disease?
Yes	**No**	Do you have any allergies? If yes, describe
Yes	**No**	Do you have a history of alcohol or drug abuse?
Yes	**No**	Do you smoke? If yes, how many packs per day? How many years?
Yes	**No**	Do you drink alcohol? If yes, how often? Times per week
Yes	**No**	Have you had any suicide attempts? If yes, how many?
Yes	**No**	Do you have any current legal issues?
Yes	**No**	Have you ever had an MRI of your brain?

List Current Medications

List Failed Psychiatric Medications

List Past and Present Medical Problems

Paul A. Buongiorno, M.D., P.A.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Re: _____ **Date of Birth:** _____.

I hereby authorize:

Name: _____.

Address: _____.

Telephone: _____ **Fax:** _____.

To release specified information to:

Name: PAUL A. BUONGIORNO, M.D. .

Address: 1402 South 17th Street, Wilmington, NC. 28401 .

Telephone: (910)762-8400 **Fax:** (910)762-9558 ***secure fax line**

This data includes:

☒ **Psychological Evaluation** ☒ **List of medications**

☒ **Laboratory Reports** ☒ **All Clinical Records**

I understand this information will be used for:

☒ **TMS CONSULTATION** ☐ **Treatment Planning**

☐ **Evaluation**

I understand this information will not be further released without my consent.

I understand that there are regulations protecting the confidentiality of authorized information and I hereby acknowledge that this consent is voluntary and valid for 1 year or until this request is fulfilled. I acknowledge that I may revoke this consent at any time by doing so in writing, knowing that action may have already been taken.

_____ _____ .

Signature of Patient or Legal Guardian Relationship to Patient

_____ . _____ .

Date Witness

PAUL A. BUONGIORNO, MD, PA

NOTICE
Your Information. Your Rights. Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please read it carefully and ask any questions if you are uncertain of the meaning of anything described below.

Your Rights
When it comes to your health information, you have certain rights. This explains your rights and some of our responsibilities to help you.

You have the right to:

- **Request a copy of your paper* or electronic medical records**.
  Electronic Record. On request, we will give you instructions on how to gain access to your electronic medical record. Your electronic medical record contains copies of your medication lists as well as some lab results.
  ***Written Therapy Records.** Due the private nature of these records, we have a procedure to request a hard copy of your treatment records that requires you to make a time to come in to our office to review the record at a time the doctor is present to answer any questions you may have. This policy is for the purposes of keeping your information private as well as for your understanding of the information your records contain. We will make every effort to accommodate your request promptly and as a time that is convenient to you. There are no exceptions to this policy.
  Request Records be sent to another provider. With an signed Release of Information, we will send your records to another medical or psychiatric provider immediately.

- **Correct your paper or electronic medical record (in writing**). You can ask us to correct health information about you that you believe is incorrect or incomplete and we will address your request in writing within 60 days to explain if your request is possible or not.

- **Request confidential communications.** You can ask us to contact you in a specific manner for example, home, mobile, office phone or to send mail to a different address. Most often we are able to accommodate all reasonable requests.

- **Ask us to limit the information we share.** You can ask us to use or share certain health information for treatment, payment or insurance operations. We will always consider your privacy and will accommodate most general requests for limiting information however, in some cases for example, if we believe it will affect your care, we may not agree to your request. For insurance purposes, claims to your insurance company will contain some private information but you can ask us not to submit claims on your behalf. However, in some instances when a law requires us, we may share some private information with your insurance company.

- **Get a list of those with whom we have shared your information.** You can request from us a list of the times we have share your health information for the past 6 years that will include who we shared your information with, what information was shared and for what purpose it was shared. PLEASE NOTE, we are unable to share your private information without a signed Release of Information from you.

- **Get a copy of this privacy notice.** You can request a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a copy promptly.

- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- **File a written complaint if you believe your privacy rights have been violated.** We protect with your private health information with the highest level of confidentiality. However, if you believe your privacy rights have been violated, we would request that you contact us immediately. You also have the right to file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending your complaint in writing to 200 Independence Avenue, S.W., Washington, DC. 20201 or by calling 877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

- **Choose who we can share your information with.**
  For certain health information, you can tell us your choices about what we share and this whom. If you have a clear preference for how we share your information, please talk to us and advise us what your instructions are.

    - You have both the right and choice to instruct us to share information with your family, close friends, or others involved in your care. However, if you are unable to tell us your preference, for example if you are unconscious, we may share relevant information if we believe it is in your best interest. We may also share you information when needed to lessen a serious and imminent threat to health and safety.
    - We do not share most psychotherapy and therapy visit notes without your specific permission in writing to do so.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

- To treat you. We can use and share your information with other professionals who are treating you. For example, a doctor treating you for an injury or condition may ask another doctor about your overall health condition.

- To run our practice. We can use and share your health information for the general running of our practice, improve your care and to contact you when necessary. For example, we use health information about you to manage your treatment and services.

- Bill for your services. You may ask us to bill your insurance company for the services you receive which will include your health information. Other entities such as life insurance requests for records may entail sharing your health information but require your signed approval.

- Help with public health and safety issues. We are allowed, in some cases, to share your information in other ways for the purposes of public health and research. We have to meet many conditions in the law before such information for these purposes can be shared. For more information, please see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. Certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, prevent or reducing a serious threat to anyone's health or safety are examples. We can also use or share your information for health research.

- Comply with the law. We will share information about you if state or federal laws require it, including the Department of Health and Human Services if it wants to see that we have complied with federal privacy law.

- Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

- Work with a medical examiner or funeral director when an individual dies.

- Address workers' compensation, law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law and other government requests such as military, national security and presidential protective services.

- Respond to lawsuits and legal actions that allows us to share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you also have the right to change your remind and revoke the authorization by informing us in writing.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office and on our web site.

Paul A. Buongiorno, MD, PA

PATIENT'S ACKNOWLEDGEMENT
OF RECEIPT TO NOTICE OF PRIVARY PRACTICES

Patient Name _____. **Date of Birth** _____.

I acknowledge that I have received a copy of the Notice of Privacy Practices of the office of Paul A. Buongiorno, MD, PA.

Patient/Authority Signature: _____. **Date:** _____.

Relationship/Authority: _____.

HIPAA Compliance Officer: _____. **Date:** _____.

Notes:

Please complete ALL information to the best of your ability.

Name _____ **Date of Birth** _____ **SS#** _____

Contact Telephone: Home _____ **Work**_____ **Cell** _____

Primary Care Physician _____ **Tel:** _____

Current Therapist/Counselor _____ **Therapist's Phone** _____

Your Email Address:_____

What are the problem(s) you are seeking help for?

_____

_____

_____

What are your treatment goals?

_____

_____

_____

Current Symptoms (check for any symptoms present, circle for major symptoms present)

- ☐ Depressed mood
- ☐ Unable to enjoy activities
- ☐ Sleep pattern disturbance
- ☐ Loss of interest
- ☐ Concentration/forgetfulness
- ☐ Change in appetite
- ☐ Fatigue
- ☐ Decreased libido
- ☐ Racing thoughts
- ☐ Impulsivity
- ☐ Increase risky behavior
- ☐ Increased libido
- ☐ Decreased need for sleep
- ☐ Excessive energy
- ☐ Crying spells
- ☐ Agitation or Rage
- ☐ Excessive worry
- ☐ Anxiety attacks
- ☐ Avoidance
- ☐ Hallucinations
- ☐ Suspiciousness
- ☐ _____
- ☐ _____

Allergies _____ Current Weight _____ Height _____

Current <u>PRESCRIPTION MEDICATIONS</u> and how often you take them. If none, write none.

_____

_____

_____

_____

Current <u>OVER-THE-COUNTER MEDICATIONS</u> or supplements including herbal. If none, write none.

_____

_____

_____

Past Medical Conditions (non-psychiatric hospitalizations or surgeries)

_____

_____

_____

Have you ever had an EKG? ☐ Yes ☐ No If yes, when _____
Was the EKG result: ☐ normal ☐ abnormal ☐ unknown?

For women only:

Date of last menstrual period Does you mood change during your cycle?
Are you currently pregnant or think you might be? ☐ Yes ☐ No
Have you ever been pregnant? ☐ Yes ☐ No
Are you planning to get pregnant in the future? ☐ Yes ☐ No

Do you have any concerns about you physical health that you would like to discuss with me? _____

_____

Date and place of last physical exam _____

PERSONAL AND FAMILY MEDICAL HISTORY state you or which family member

Thyroid Disease _____ Anemia _____
Liver Disease _____ Chronic Fatigue _____
Fibromyalgia _____ Chronic Pain _____
Kidney Disease _____ Diabetes _____
Asthma/respiratory problems _____ Stomach or intestinal problems _____
Cancer (type) _____ Heart Disease _____
Epilepsy or seizures _____ High Cholesterol _____
High blood pressure _____ Head trauma _____
Other _____

Is there any additional personal or family medical history?
If so, please explain _____

When your mother was pregnant with you, were there any complications during the pregnancy?
If so, please explain _____

PERSONAL AND FAMILY PSYCHIATRIC HISTORY

Have you or any direct family member been diagnosed with or treated for:

Bipolar disorder ☐ Yes ☐ No You ☐ or which family member _____

Depression ☐ Yes ☐ No You ☐ or which family member _____

Anxiety ☐ Yes ☐ No You ☐ or which family member _____

Anger ☐ Yes ☐ No You ☐ or which family member _____

Suicide ☐ Yes ☐ No Which family member _____
Schizophrenia ☐ Yes ☐ No You ☐ or which family member _____

Post-traumatic stress ☐ Yes ☐ No You ☐ or which family member _____

Alcohol abuse ☐ Yes ☐ No You ☐ or which family member _____

Other substance abuse ☐ Yes ☐ No You ☐ or which family member _____

Violence ☐ Yes ☐ No You ☐ or which family member _____

If you answered yes to any of the above psychiatric history, did you receive?

Outpatient treatment? ☐ Yes ☐ No If yes, dates of treatment _____

Reason for treatment _____ Who treated you _____

Psychiatric Hospitalization? ☐ Yes ☐ No Date of hospitalization _____

Reason for hospitalization _____ Where _____

Has a family member ever received psychiatric treatment with medications? ☐ Yes ☐ No

Name of Medication _____ Did it work? _____

List your past psychiatric medications (dates, dose and response are helpful if possible)

Antidepressant	**Dates**	**Dose**	**Response/side effects/Reason for discontinuing**
Prozac (fluoxetine)			
Zoloft (sertraline)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Paxil (paroxetine)			
Effexor (venlafaxine)			
Luvox (fluvoxamine)			
Wellbutrin (buppropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Cymbalta (duloxetine)			
Serzone (efazodone)			
Anafranil (clomipramine)			
Pamelor (nortriptyline)			
Tofranil (imipramine)			
Elavil (amatriptyline)			
other			

Mood Stabilizers	**Dates**	**Dose**	**Response/Side Effects/Reason for discontinuing**
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Topamax (topiramate)			
other			

Antipsychotics/Mood Stabilizers **4**

Seroquel (quetiapine) _____ _____ _____
Zyprexa (olanzapine) _____ _____ _____
Risperdal (respirdone) _____ _____ _____
Geodon (ziprasidone) _____ _____ _____
Abilify (aripiprazole) _____ _____ _____
Clozaril (clozapine) _____ _____ _____
Haldol (haloperidol) _____ _____ _____
Prolixin (fluphenazine) _____ _____ _____
other _____ _____ _____

Sedative Hypnotics

Ambien (zolpidem) _____ _____ _____
Klonopin (clonazepam) _____ _____ _____
Sonata (zaleplon) _____ _____ _____
Rozerem (ramelteon) _____ _____ _____
Restoril (temazepam) _____ _____ _____
Desyrel (trazodone) _____ _____ _____
other _____ _____ _____

ADHD Medicatons

Adderall (amphetamine) _____ _____ _____
Concerta (methylphenidate) _____ _____ _____
Ritalin (methylphenidate) _____ _____ _____
Strattera (atomoxetine) _____ _____ _____
other _____ _____ _____

Antianxiety Medication

Xanax (alprazolam) _____ _____ _____
Ativan (lorazepam) _____ _____ _____
Klonopin (clozaepam) _____ _____ _____
Valium (diazepam) _____ _____ _____
Tranxene (clorazepate) _____ _____ _____
Buspar (buspirone) _____ _____ _____
other _____ _____ _____

Do you exercise? ☐ Yes ☐ No How many days a week to you get exercise? _____

When you exercise, what kind of exercise do you do? _____ How long for? _____

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No If yes, what kind (beer/wine/cocktail) _____
If so, how many days per week do you drink alcohol? _____

What is the least number of drinks do you drink in a day _____

What is the most number of drinks do you drink in a day _____

How many caffeinated beverages do you drink in a day? Coffee _____ Soda _____ Tea _____

Have you ever smoked cigarettes? ☐ Yes ☐ No

Current? ☐ Yes ☐ No If yes, how many packs per day on average? _____ How many years _____

In the past How many years did you smoke? _____ When did you quit? _____

Have you ever smoked a pipe, smoked cigars or chewed tobacco? (Circle) ◯ Currently? Previously? ◯

Have you ever used or abused drugs? ☐ Yes ☐ No What _____ When _____ How often _____

Have you ever used or abused prescription medications? ☐ Yes ☐ No

BACKGROUND HISTORY

Were you adopted? ☐ Yes ☐ No Where did you grow up? _____

List your siblings and their ages _____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parent divorce? ☐ Yes ☐ No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Describe your father and your relationship with him _____

Describe your mother and your relationship with her _____

How old were you when you left home? _____

Has anyone in your immediate family died? _____ Who and when? _____

Do you have a history of being abused emotionally, sexually, physically or by neglected? ☐ Yes ☐ No

EDUCATION

Did you attend college? _____ Where? _____ Major? _____

What is your highest educational level or degree attained? _____

OCCUPATIONAL HISTORY

Are you currently ☐ working ☐ not working by choice ☐ Unemployed ☐ disabled ☐ retired

What is your occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Honorable discharge? ☐ Yes ☐ No

RELATIONSHIP HISTORY

Are you currently ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Describe your relationship with your spouse or significant other _____

Have you had any prior marriages? ☐ Yes ☐ No If so, how many? _____

Do you have children? ☐ Yes ☐ No. If yes, list ages and gender _____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

Is there anything else that you would like us to know? _____

_____

Signature _____ Date _____

Emergency Contact and relationship _____ Telephone # _____

Can we leave messages for you at home? ☐ Yes ☐ No At work? ☐ Yes ☐ No

Reviewed by _____ Date _____

WHODAS 2.0

World Health Organization Disability Assessment Schedule 2.0

12 item version, self administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response

	In the past 30 days, how much difficulty did you have in	**1= None**	**2=Mild**	**3=Moderate**	**4=Severe**	**5=Extreme or cannot do**
S1	Standing for long periods such as 30 minutes?					
S2	Taking care of your household responsibilities?					
S3	Learning a new task, for example, learning how to get to a new place?					
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?					
S5	How much have you been emotionally affected by your health problems?					
S6	Concentrating on doing something for ten minutes?					
S7	Walking a long distance such as a kilometer (or equivalent)?					
S8	Washing your whole body?					
S9	Getting dressed?					
S10	Dealing with people you do not know?					
S11	Maintaining a friendship?					
S12	Your day to day work?					

Total		0	0	0	0	0

0
out of 60