Alpine TMS - PATIENT INFORMATION

Please complete all information and write clearly. Please ask for assistance if needed.

Alpine Health Centre

P: 1300 360 791
F: 1300 360 798
E: info@alpinehc.au
W: www.alpinehc.au

☐ 40 Prince St, Rosedale VIC 3847
☐ 4 Gippsland St, Jindabyne NSW 2627

PATIENT DETAILS

Date: .....

Surname: .....

FName: .....

Address: .....

.....

DOB: ..... **Age:** **Gender:**

Ph: ..... **Mobile:** .....

Email: .....

Please answer the following questions to the best of your ability, providing as much detail as possible.
If you cannot answer some of the questions, a Registered Nurse (RN) and/or Psychiatrist will assist you.

PLEASE INDICATE IF ANY OF THE FOLLOWING CONDITIONS APPLY TO YOU:

☐ Epilepsy or Past Seizures ☐ Neurosurgery ☐ Cochlear Implant
☐ Implantable Medical Devices ☐ Pacemaker

CONDITIONS:

☐ Depression
☐ Anxiety
☐ PTSD
☐ OCD
☐ Pain
☐ Acquired Brain Injury
☐ Other:

CLINICAL DETAILS:

Please provide more information about your symptoms and how long the symptoms have been present for the identified condition/s.

ANYTHING CAUSING YOU STRESS (for example finances, relationships or physical pain etc.):

PATIENT HEALTH INFORMATION

Have you had TMS in the Past? ☐ Yes ☐ No **Details:**

If yes, were there any adverse reactions? ☐ Yes ☐ No **Details:**

Do you have epilepsy? ☐ Yes ☐ No **Last seizure:**

Do you have syncope? ☐ Yes ☐ No **Last syncope:**

Have you had a stroke? ☐ Yes ☐ No **Details:**

Have you had a head injury or neurosurgery? ☐ Yes ☐ No **Details:**

Have you had retinal concerns? ☐ Yes ☐ No **Details:**

Are You? ☐ Left-handed ☐ Right-handed ☐ Mixed

Do you have a cardiac pacemaker? ☐ Yes ☐ No **Details:**

Do you have a medication infusion device? ☐ Yes ☐ No **Details:**

Do you have tinnitus? ☐ Yes ☐ No **Details:**

Do you have cochlear implants? ☐ Yes ☐ No **Details:**

Do you suffer from frequent headaches? ☐ Yes ☐ No **Details:**

Do you have any back or neck issues? ☐ Yes ☐ No **Details:**

Are you pregnant? ☐ Yes ☐ No **Details:**

Are you taking any recreational drugs? ☐ Yes ☐ No **Details:**

Are you taking prescribed medication? ☐ Yes ☐ No **If YES, please list the medication below:**

MEDICATION (prescribed and over the counter medication, e.g. vitamins, melatonin etc.)**:**

Current Medication	Dose	Yr Started	Reason for prescription

Previous Medication received for mental health conditions:

Past & Current Psychological Treatments Received (Psychotherapy, CBT, EMDR, etc.)

Mental Health professionals or services involved in your care:

.

Family Mental Health History (parents, grandparents, siblings and children)**:**

How would you describe your personality, strengths and weaknesses:

What strategies or "coping mechanisms" do you use:

How would you describe your childhood:

Briefly describe your experience at school, educational level attained and profession:

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Did you suffer from any childhood conditions (school refusal, separation anxiety, enuresis, ADHD or ASD)**:**

Have you experienced any physical and or phycological trauma (please provide details)**:**

Describe your current social situation (relationship/friendships/living arrangements)**:**

.

Describe your typical week of activity (occupation, work, leisure, family, social, hobbies)**:**

Sleep routine (time you go to bed / wake up / trouble settling / average hours of sleep each night)**:**

Daily alcohol consumption (type, quantity, frequency, including binge drinking)**:**

Do you use THC (cannabis) or other substances (please provide details)**:**

Do you have a history of addiction to any substances (including prescription medication)**:**

What are your short term and long-term goals:

SHORT-TERM goals:

LONG-TERM goals:

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Additional information about your mental health, comments or concerns:

Local General Practitioner (GP) or Nurse Practitioner (NP):

GP/NP: PRACTICE NAME:

ADDRESS:

PHONE: EMAIL:

Specialist / Therapist / Allied Health:

NAME: PRACTICE NAME:

ADDRESS:

PHONE: EMAIL:

Treatment Provided:

Specialist / Therapist / Allied Health:

NAME: PRACTICE NAME:

ADDRESS:

PHONE: EMAIL:

Treatment Provided:

Specialist / Therapist / Allied Health:

NAME: PRACTICE NAME:

ADDRESS:

PHONE: EMAIL:

Treatment Provided:

Specialist / Therapist / Allied Health:

NAME: PRACTICE NAME:

ADDRESS:

PHONE: EMAIL:

Treatment Provided:

Service Provider (Aged Care, NDIS or other services)**:**

NAME: PRACTICE NAME:

ADDRESS:

PHONE: EMAIL:

Services Provided:

Service Provider (Aged Care, NDIS or other services)**:**

NAME: PRACTICE NAME:

ADDRESS:

PHONE: EMAIL:

Services Provided: