DENT NEUROLOGIC INSTITUTE

716.250.2000 | dentinstitute.com
Amherst | 3980 Sheridan Drive • Amherst, NY 14226
Orchard Park | 200 Sterling Drive • Orchard Park, NY 14127
Buffalo | 40 George Karl Boulevard • Buffalo, NY 14221

Dear Patient:

Thank you for choosing the Dent Neurologic Institute, Western New York's premier Neurologic and Diagnostic Center.

Patients are required to arrive 30 minutes prior to their appointment time for the initial consultation. This time will be used to complete the registration process. Thank you for your understanding!

In order to ensure a positive experience, please be prepared with the following items on the day of your visit. Failure to comply may result in our need to reschedule your visit.

★ **Documents:** You must complete all the enclosed documents prior to your appointment time. COMPLETION OF YOUR MEDICAL INTAKE FORMS IS CRITIAL IN ORDER FOR OUR PHYSICIANS APPROPRIATELY TREAT AND DIAGNOSIS. If your visit is related to a work or motor vehicle accident, you must complete the application forms in their entirety.

★ **Insurance Card:** You must provide us with your insurance card.

★ **Payment:** If you have a co-pay or high deductible plan, you must bring payment with you; if you have a high deductible plan $200 is required at the time of service; any remaining responsibility will be billed to you.

★ **Identification:** You must provide us with photo ID or two other forms of identification.

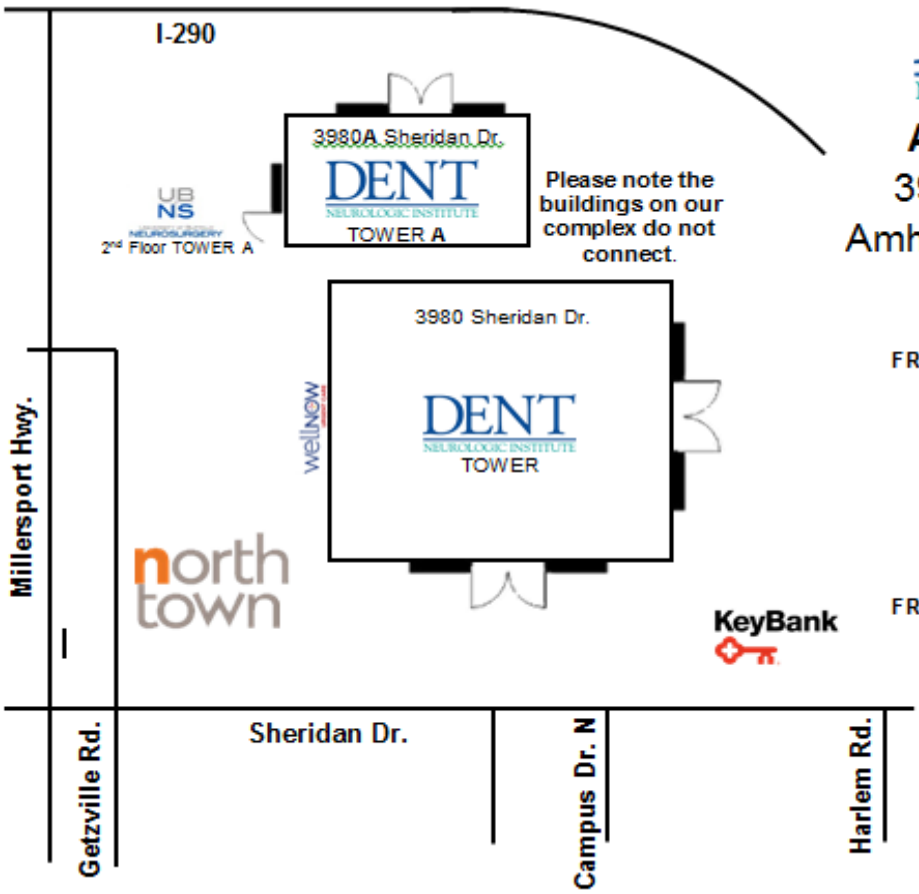
★ **Diagnostic Results:** Test results, diagnostic reports, films and CDs from all physicians treating you are REQUIRED at visit.

Be sure to visit our website at www.dentinstitute.com for insurances we accept and access to your on-line secured medical record.

Once again, thank you for choosing the Dent Neurologic Institute. If you have any questions, please feel free to call our Center at 716-250-2000.

Advance Notice is Required for all Cancellations

If you fail to cancel an appointment at least one business day prior; or you do not show for your scheduled appointment, you will be assessed a non-timely cancellation fee.



DENT
NEUROLOGIC INSTITUTE

Amherst Location

3980 Sheridan Drive
Amherst, New York 14226

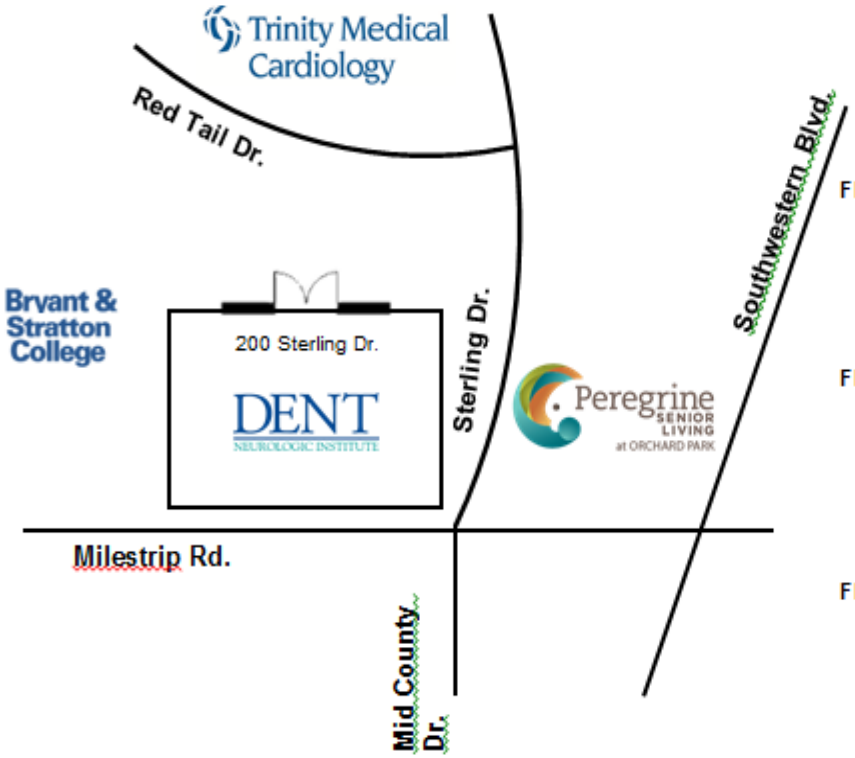
DRIVING DIRECTIONS:

FROM NIAGARA FALLS/NORTH TOWNS

- Robert Moses Parkway South
- I-190 South
- I-290 East
  (Youngman Exp/Exit 16 towards I-90)
- Exit Harlem Road (Exit 6)
- Right onto Harlem Road
- Left onto Sheridan Drive
- Right at light into Dent Tower

FROM SOUTH TOWNS

- I-190 East
- Merge into I-290
  (Youngman Exp/Exit 50)
- Exit Sheridan Drive (Exit 6)
- Left onto Sheridan Drive
- Right at light into Dent Tower



Orchard Park Location

200 Sterling Drive
Orchard Park, NY 14127

DRIVING DIRECTIONS:

FROM SOUTH TOWNS

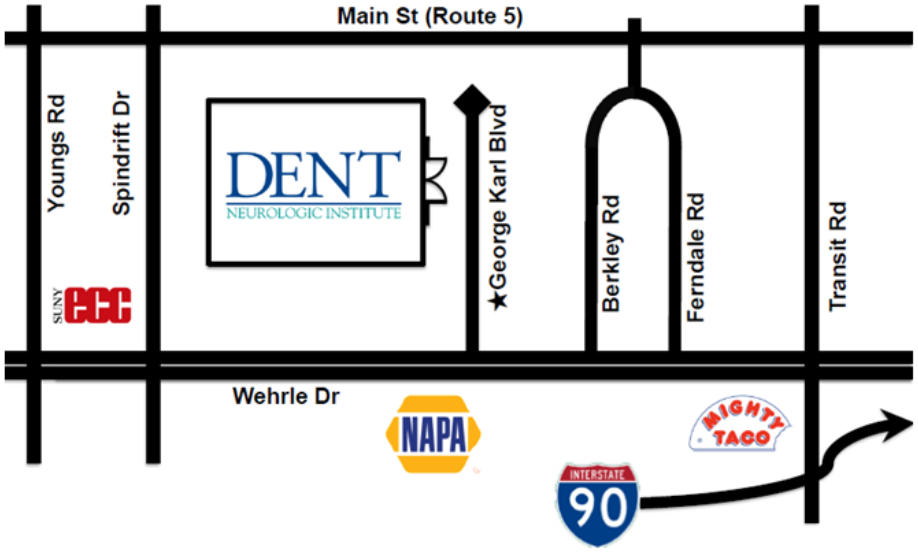
- Route 219 N to Milestrip Road East
  (1st Exit onto Milestrip Road)
- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM BUFFALO

- Thruway (90) West to Route 219
- Exit Milestrip Road East
  (2nd Exit onto Milestrip Road)
- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM PENNSYLVANIA

- Thruway (90) East to Exit 56
- Left onto Milestrip Road
- Left onto Sterling Drive
- Left on Red Tail
- Left into parking lot



Buffalo Location
40 George Karl Boulevard
Buffalo, NY 14221
Suite 120

From Niagara Falls

- I-190 South toward Buffalo
- Exit 16 for I-290 East toward Rochester/ Tonawanda
- Take ramp left for Thruway I-90 East toward Albany (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

From Buffalo

- Route 33 East toward Airport
- Take ramp right for Thruway I-90 East toward Albany (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

From Southtowns

- Route 219 North toward Buffalo
- Take ramp right for Thruway I-90 East toward Buffalo (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

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DENT NEUROLOGIC INSTITUTE

REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Last Name:		**Middle:**	**First Name:**
❑ Mr. / ❑ Mrs. / ❑ Miss / ❑ Ms.		**Marital Status (Check one):**	❑ Single / ❑ Married / ❑ Divorced ❑ Separated / ❑ Widowed
Former Name:		**Preferred Name:**	
Birth Date:	**Sex:** ❑ M ❑ F	**E-mail Address:**	
Home Phone: ( )		**Cell Phone:** ( )	
Street Address or P.O. Box:			
City:	**State:**	**Zip Code:**	**Social Security Number:**
Primary Physician:		**Referring Physician:**	
Race:	**Ethnicity:**		**Language:**
Pharmacy Name:	**Pharmacy Address:**		**Pharmacy Phone:**
CONTACT PERSON IN CASE OF EMERGENCY			
Name:		**Relationship:**	
Home Phone: ( )		**Cell Phone:** ( )	
SEXUAL ORIENTATION / GENDER IDENTITY			
Sexual Orientation (Check one):	❑ Lesbian, gay or homosexual / ❑ Straight or heterosexual ❑ Bisexual / ❑ Do not know / ❑ Choose not to disclose		
	Something else, please describe:		
Gender Identity (Check one):	❑ Male / ❑ Female / ❑ Female-to-Male (FTM), Transgender Male, Trans Man ❑ Male-to Female (MTF), Transgender Female, Trans Woman ❑ Genderqueer, neither exclusively male nor female ❑ Choose not to disclose		
	Additional gender category or other, please specify:		

DENT NEUROLOGIC INSTITUTE
INSURANCE INFORMATION

You will need to give your insurance card to the receptionist			
Person Responsible for Bill (if not self):	**Address (if different):**	**Home Phone: ( )**	
		Cell Phone: ( )	
Birth Date: / /	**Occupation:**		
Responsible Party's Employer:	**Employer Address:**	**Employer Phone: ( )**	
PRIMARY INSURANCE	**Insurance Plan:**		
Policy No:	**Group No:**		
Subscriber's Name (if not self):	**Subscriber's SSN:**	**Co-pay Amount:**	
	Subscribers DOB: / /		
Patient's Relationship to Subscriber (Check one):	❑ **Self** ❑ **Spouse** ❑ **Child** ❑ **Other**		
SECONDARY INSURANCE	**Insurance Plan:**		
Policy No:	**Group No:**		
Subscriber's Name (if not self):	**Subscriber's SSN:**		
	Subscribers DOB: / /		
Patient's Relationship to Subscriber (Check one):	❑ **Self** ❑ **Spouse** ❑ **Child** ❑ **Other**		

IF YOUR APPOINTMENT IS THE RESULT OF AN ACCIDENT OR INJURY,
YOU MUST COMPLETE THE ENCLOSED NO-FAULT OR WORKERS COMP FORM

PLEASE READ

Important Insurance Plan Information

Before being seen, please review the following insurance participation information. Deductibles, co-insurances and co-pays are due at time of service. Estimated cost of an office visit ranges from $75 - $200; estimates for office procedures will be provided separately. If you have any questions or would like to receive an estimate for services, please call our Business Office at 250-2010.

DENT Participates with:

- Blue Cross Blue Shield (including Align programs)
- Empire
- Fidelis (**Not Accepting New Adult Patients**)
- Independent Health
- MagnaCare (including Health Republic)
- MVP (excluding Individual Exchange plans)
- Nova
- RMSCO (aka Lifetime Benefits Solutions)
- United Healthcare (Commercial and Medicare plans only)
- Univera
- Medicare and Medicare Railroad
- NYS Medicaid
- Wellcare (**Not Accepting New Patients**)
- Excellus - Blue Cross Plans (does not include Medicare Blue Choice Value/ Optimum or Monroe Medicaid plans)
- Martin's Point (varies by doctor)
- YourCare

DENT does NOT Participate with:

- Aetna (unless part of MultiPlan which varies by doctor)
- Cigna (unless part of MultiPlan which varies by doctor)
- Coventry/Health America
- Emblem Health/GHI -Imaging ONLY
- Excellus Plans (Premier Option)
- MVP (Individual Exchange plans)
- MultiPlan (varies by doctor)
- UPMC
- United Healthcare (Medicaid plans)
- Out of State Medicaid

In every case we will bill your insurance carrier on your behalf. Based on participation status you may have additional out-of-pocket expenses. We recommend you call your carrier directly to verify individual physician coverage.

Your insurance carrier may require you to utilize a specific laboratory testing facility. Please be sure to confirm this with the office staff.

Hospital Affiliations: Kaleida Health; Mercy Hospital of Buffalo

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DENT NEUROLOGIC INSTITUTE

WORKERS COMPENSATION

SUPPLEMENTAL INFORMATION FORM

Today's Date:	Date of Birth:	
Patient Name:	Social Security No:	
Date of Injury:		
Employer Name:	Employer Address:	
Employer Phone Number: ( )	Your Job Title:	Are you out of work due to this injury: ❑ Yes ❑ No

COMPENSATION INSURANCE CARRIER INFORMATION

Insurance Carrier Name:	Insurance Carrier Address:
Carrier Claim Number:	WCB Case Number:
Name of Case Manager:	Phone: ( )
	Fax: ( )
Briefly Describe the Injury you Sustained:	
Briefly Describe how Injury Occurred:	

ATTORNEY INFORMATION

Attorney Name:	Attorney Address:
Phone: ( )	Fax: ( )

Please bring all Insurance Carrier and Workers Compensation Board information with you to your appointment. We may need to reschedule your appointment should you fail to include critical information concerning your Carrier.

DENT NEUROLOGIC INSTITUTE

NO-FAULT

SUPPLEMENTAL INFORMATION FORM

Patient Name:	Date of Birth: Social Security No:
Date of Accident:	Are You Currently Out of Work as a Result of this Accident: ❑ Yes ❑ No
Injury Sustained:	
INSURANCE CARRIER INFORMATION	
Insurance Carrier Name:	Insurance Carrier Address:
Name of Adjuster:	Claim Number:
Phone: ( )	Fax: ( )
ACCIDENT DETAILS	
Location of Accident:	
Briefly Describe how the Accident Occurred:	
Were you a: ❑ Driver ❑ Passenger ❑ Pedestrian	
If Driver or Passenger, were you: ❑ Belted ❑ Not-Belted	
Have you Filed a Claim with your Carrier: ❑ Yes ❑ No	Have you Completed and Returned your No-Fault Application: ❑ Yes ❑ No
ATTORNEY INFORMATION	
Attorney Name:	Attorney Address:
Phone: ( ) Fax: ( )	
Signature:	**Date:**

FOR OFFICE USE ONLY

PROVIDER: **DENT NEUROLOGIC GROUP** **PO Box 8000 Dept 057** **Buffalo, NY 14267** **Signature: _____**	**CLAIM# _____** **DATE OF LOSS: _____** **CARRIER: _____**

Today's Date: _____

For Office Use Only
MDQ: _____ **PHQ-9**:_____ **GAD-7**: _____

1. General Information:

Name:_____ Sex: M / F Date of Birth: _____ Age: _____

SS #: _____ Marital Status: Single/Married/Separated/Divorced/Widowed
Name of Referring Physician: _____ Phone #: _____
Name of Primary Care Physician: _____ Phone #: _____
Name of Therapist/Counselor: _____ Phone #: _____

2. Problem: Please write the reason(s) you are seeing a psychiatrist:

_____
_____
_____
_____
_____

Do you have problems with sleep? □ Yes □ No
If so, what are they? (M*ark all that apply*)

□ Can't fall asleep □ Interrupted sleep □ Wake up tired □ Sleep too much
□ Legs moving □ Snoring □ Nightmares

Do you have problems with any of the following? (M*ark all that apply*)

□ Appetite □ Memory □ Level of energy □ Anxiety/Worry
□ Panic □ Staying focused □ Distractibility □ Irritability
□ Impulsiveness □ Racing thoughts

Please list all medications you are <u>currently taking</u> with dosages: (include vitamins/supplements)

Name of Medication:	***Dose (How much do you take):***	***Frequency (When do you take):***

3. MEDICAL HISTORY:

Height: _____ft. _____ in. Weight: _____ lb. □ Left-handed □ Right-handed

Do you have any of the following medical conditions?

❑ Diabetes	□ High blood pressure□	□ Heart disease	□ Migraines
❑ Thyroid problems	□ Seizures/Epilepsy	□ IBS/IBD	□ Fibromyalgia
❑ Chronic Fatigue	□ Chronic Pain	□ Back injury	□ Osteoporosis
❑ Rheumatoid arthritis	□ Hypogonadism	□ Liver disease	□ Head injury

If yes to head injury, any loss of consciousness? □ Yes □ No
Longer than five minutes? □ Yes □ No
Have you ever had a DEXA scan? □ Yes □ No
Have you ever been on oral steroids for more than 3 months? □ Yes □ No
Have you ever been on an enzyme-inducing anticonvulsant? □ Yes □ No

Please list any additional medical conditions: _____
_____
_____

Do you have any allergies or known drug allergies? □ Yes □ No
If yes, please list and include your reaction(s): _____
_____
_____

Please list any hospitalizations and/or surgeries: _____
_____
_____

FOR WOMEN: Date of your last period: _____
Are you currently pregnant or trying to become pregnant? □ Yes □ No
Are you currently breastfeeding? □ Yes □ No
Are you currently on birth control? □ Yes □ No
Are you currently on hormone replacement therapy? □ Yes □ No

4. PRIOR PSYCHIATRIC HISTORY:

Have you ever seen a: (*mark all that apply*)
□ Psychiatrist □ Psychologist □ Therapist □ Counselor
If so, please list who and when:
Name: _____ Dates: _____
Name: _____ Dates: _____
Name: _____ Dates: _____
Additional names: _____

Have you ever been hospitalized for a psychiatric disorder? □ Yes □ No
If so, please list where and when:
Facility: _____ Dates: _____
Facility: _____ Dates: _____
Facility: _____ Dates: _____
Additional information: _____
_____
_____
_____

Name: _____ DOB: _____

5. PRIOR PSYCHIATRIC HISTORY(Continued):

Have you ever tried to hurt yourself or others? □ Yes □ No

If so, please list who and when:

_____

_____

_____

6. FAMILY PSYCHIATRIC HISTORY:

Please describe any family history of psychiatric illness, mental health treatment, alcoholism, or drug use: (Parents, siblings, extended family members)

_____

_____

_____

Has anyone: □ Been psychiatrically hospitalized □ Received psychiatric treatment □ Neither

If yes, who? _____

Has anyone attempted to commit suicide? □ Yes □ No If yes, who? _____

Has anyone committed suicide? □ Yes □ No If yes, who? _____

7. FAMILY MEDICAL HISTORY (Diabetes, Stroke, Heart Disease, Cancer, etc.):

Please list any medical conditions of the following family members:

Father: _____

Alive? □ Yes □ No If no, cause of death and/or illness: _____

Mother: _____

Alive? □ Yes □ No If no, cause of death and/or illness: _____

8. SUBSTANCE USE/ABUSE HISTORY:

Have you ever had any alcohol? □ Yes □ No

Age when you first had a drink: _____ How often do you drink? _____

Date you last drank: _____ Drink of choice? □ Beer □ Wine □ Liquor

Have you ever used illicit / street drugs? □ Yes □ No

If yes, please list: _____

Age you first used drugs: _____ How often do you use drugs? _____

Date you last used drugs: _____ What did you use? _____

Have you ever smoked tobacco? □ Yes □ No

Age you first smoked tobacco: _____ Are you currently a smoker? □ Yes □ No

How often do you smoke? _____ How many packs per day? _____

Number of attempts at quitting: _____ Date you quit: _____

Have you previously been tried on: (*Circle all that apply*)

Naltrexone	**Campral**	**Antabuse**	**Vivitrol**	**Methadone**
Suboxone	**Zubsolv**	**Subutex**	**Sublocade**	**Buprenorphine**

Have you sought substance/alcohol abuse treatment in the past? ❑ Yes ❑ No

Are you currently involved in substance/alcohol abuse treatment? ❑ Yes ❑ No

Name: _____ DOB: _____

Do you currently have or had in the past any legal issues related to substance or alcohol?

❑ Yes ❑ No

Please list all treatment programs you have been involved in or are currently involved in:

(Please include dates, length of treatment, any AA/NA/SOS meetings, frequency per week, sponsor)

_____

_____

_____

_____

_____

9. SOCIAL HISTORY:

Please list whom you live with: _____

_____

Do you have a good support system? (Including family and/or friends) □ Yes □ No

If yes, please list who: _____

_____

Do you have any children? □ Yes □ No If yes, how many? _____

_____

10. LEGAL:

Do you have any pending legal issues? □ Yes □ No

If yes, what are they? _____

_____

Do you have any pending court appearances? □ Yes □ No

If yes, please list when and what for: _____

_____

11. WORK:

Are you currently employed? □ Yes □ No

Current title/position: _____ Employer: _____

Are you currently on disability? □ Yes □ No

If yes, date you became disabled: _____ Who put you on disability? _____

12. INTERESTS/LEISURE:

Please list any hobbies/activities you enjoy: _____

_____

13. DEVELOPMENT:

Birth history: □ Full term □ Preterm

Delivery: □ C-section □ Vaginal

Complications: □ Yes □ No

If yes, please list: _____

_____

How did you do in elementary school? _____

Did you have any delays in walking, talking, or reading? □ Yes □ No

If yes, what were they? _____

_____

Name: _____ DOB: _____

Did you require any special classes or accommodations? □ Yes □ No
If yes, what classes? _____
Highest grade or level of education completed: _____
Have you ever been abused: (*Mark all that apply*)
□ Emotionally □ Physically □ Sexually

14. Is there anything else you would like to add about yourself that has not been covered?

_____
_____
_____
_____
_____
_____
_____

Thank you.

Name: _____ DOB: _____

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Name: _____ DOB:

Mood Disorder Questionnaire (MDQ)

Instructions: Please answer each question as best as you can.

1. Has there ever been a period of time when you were not your usual self and…	Yes	No
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got in trouble?	☐	☐
…you were so irritable that you shouted at people or started fights or arguments?	☐	☐
…you felt much more self-confident than usual?	☐	☐
…you got much less sleep than usual and found you didn't really miss it?	☐	☐
…you were much more talkative or spoke much faster than usual?	☐	☐
...your thoughts raced through your head or you couldn't slow your mind down?	☐	☐
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
…you had much more energy than usual?	☐	☐
…you were much more active or did many more things than usual?	☐	☐
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
…you were much more interested in sex than usual?	☐	☐
…you did things that were unusual for you or that other people might have thought were excessive, risky, or foolish?	☐	☐
…spending money got you or your family in trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights?
Please circle one response only

No problem Minor problem Moderate problem Serious problem

4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

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Please complete to the best of your ability of which of the following medications you have previously tried. If possible, please add at what dose you tried, dates taken, and any side effects or adverse effects. Thank you.

Medications Trials						
CLASSIFACTION	**Check If Tried**	**Brand Name**	**Generic Name**	**Doses Tried**	**Dates Used**	**Side Effects?**
SSRI		Celexa	citalopram			
		Lexapro	escitalopram			
		Luvox	fluvoxamine			
		Paxil	paroxetine			
		Paxil CR	paroxetine			
		Prozac	fluoxetine			
		Zoloft	sertraline			
SNRI		Cymbalta	duloxetine			
		Effexor (XR)	venlafaxine (ER)			
		Fetzima	levmilnacipran			
		Pristiq	desvenlafexine			
		Savella	milnacipran			
Other Antidepressants		Desyrel	trazodone			
		Remeron	mirtazapine			
		Serzone	nefazodone			
		Trintellix	vortioxetine			
		Viibryd	vilazodone			
		Wellbutrin (SR)(XL)	buproprion			
Tricyclic Antidepressants		Anafranil	clomipramine			
		Asendin	amoxapine			
		Elavil	amitriptyline			
		Norpramin	desipramine			
		Pamelor	nortriptyline			
		Sinequan	doxepin			
		Surmontil	trimipramine			
		Tofranil	imipramine			
MAOI		EMSAM	selegiline			
		Nardil	phenelzine			
		Parnate	tranylcypromine			
Medications Trials						

CLASSIFACTION	Check If Tried	Brand Name	Generic Name	Doses Tried	Dates Used	Side Effects?
Mood Stabilizers/ Anticonvulsants		Depakote	valproic acid			
		Depakote (ER)	divalproex sodium			
		Horizant	gabapentin enacarbil			
		Keppra	levetiracetam			
		Lamictal (XR)	lamotrigine			
		Lithium	lithobid			
		Lyrica	pregabalin			
		Neurontin	gabapentin			
		Tegretol	carbamazepine			
		Topamax	topiramate			
		Trileptal	oxcarbazapine			
		Zonegran	zonisamide			
Antipsychotics		Abilify	aripiprazole			
		Abilify Maintena	aripiprazole injectable			
		Aristada	aripiprazole lauroxil			
		Clozaril	clozapine			
		Fanapt	lloperidone			
		Fluphenazine	prolixin			
		Geodon	ziprasidone			
		Haldol	haloperidone			
		Haldol Decanoate	haloperidol			
		Invega	paliperidone			
		Invega Sustenna	paliperidone palmitate			
		Invega Trinza	paliperidone palmitate			
		Latuda	lurasidone			
		Loxapine	loxitane			
		Mellaril	thioridazine			
		Navane	thiothixene			
		Orap	pimozide			
		Phenergan	promethazine			
		Rexulti	brexpiprazole			
		Risperdal	risperidone			
		Risperdal Consta	risperidone (ER)			
		Saphris	asenapine			
		Seroquel (XR)	quetiapine			
		Symbyax	fluoxetine /olanzapine			
		Thorazine	chlorpromazine			
		Trifluoperazine	stelazine			

Medications Trials

	Check If			Doses	Dates	Side

CLASSIFACTION	Tried	Brand Name	Generic Name	Tried	Used	Effects?
Antipsychotics continued		Trilafon	perphenazine			
		Vraylar	cariprazine			
		Zyprexa	olanzapine			
		Zyprexa Relprevv	olanzapine (ER)			
Benzodiazepines / Anxiolytics		Ativan	lorazepam			
		Buspar	buspirone			
		Inderal	propranolol			
		Klonopin	clonazepam			
		Librium	chlordiazepoxide			
		Oxazepam	oxazepam			
		Restoril	temazepam			
		Tranxene	clorazepate			
		Valium	diazepam			
		Vistaril	hydroxyzine			
		Xanax	alprazolam			
Stimulants		Adderall (XR)	amphetamine			
		Concerta	methylphenidate			
		Desoxyn	methamphetamine			
		Dexedrine	dextroamphetamine			
		Evekeo	amphetamine			
		Focalin (XR)	dexmethylphenidate			
		Ritalin	methylphenidate			
		Vyvanse	lisdexamfetamine			
Misc Stimulants		Catapres	clonidine			
		Intuniv	guanfacine			
		Nuvigil	armodafinil			
		Provigil	modafinil			
		Strattera	atomoxetine			
Sleep Aids		Ambien (CR)	zolpidem			
		Belsomra	sovorexant			
		Lunesta	eszopiclone			
		Melatonin	melatonin			
		Rozerem	ramelteon			
		Sonata	zaleplon			
		Unisom	doxylamine			

Medications Trials						
CLASSIFACTION	**Check If Tried**	**Brand Name**	**Generic Name**	**Doses Tried**	**Dates Used**	**Side Effects?**
Supplements		Deplin	levomefolic acid			
		Folic Acid	folate			
		Omega 3 Fatty Acid				
		Vitamin D				
		Vitamin B12				

Non-Pharmacological Therapies		
Therapy	**Date Range**	**Location**
Transcranial Magnetic Stimulation (TMS)		
Electroconvulsive Therapy (ECT)		
Ketamine Therapy		

Psychotherapy		
Therapist Name	**Date Range**	**Location**
Thank you!		

I acknowledge that the above information is correct and co-relates with my psychiatric history to the best of my knowledge.

Print Name: _____ **DOB:** _____

_____ **Date**: _____

Signature