Ascension Seton

Neuromodulation Consult Questionnaire

Patient Name and DOB: _____ ____/ ____/ _____

Current Referring Provider: _____

Current Primary Care Provider:_____

In a few sentences - what brings you in for this consultation today?

_____

_____

_____

Current Medication List: (Please use additional space on back if needed)

Medication Name	Dosage	Date Started	Effectiveness

Psychiatric History:

When did you start mental health treatment (Therapy or Medications)?

Have you been hospitalized for a psychiatric reason? If so, please provide dates and facility name:

Have you ever attempted suicide? If so, please list date(s) of attempt(s)

Have you ever participated in an intensive outpatient therapy program (IOP/PHP)?

Have you had previous Neuromodulation Treatment
ECT (Electroconvulsive therapy) Y/N - If yes, dates of treatment _____
TMS (Transcranial Magnetic Stimulation) Y/N - If yes, dates of treatment _____
Ketamine (Spravato, Infusions) Y/N - If yes, dates of treatment _____

Please list any previous psychiatric medications you can recall:

Medication Name	Dosage	Dates	Effectiveness

Previous Medical History: Please list current active medical diagnoses for which you receive treatment (Heart Attacks, Strokes, Pulmonary, Sleep Apnea, Hypertension, Diabetes)

Medication Allergies:

Previous Surgeries / Implantable Devices: (Procedure, Date)

History of Side Effects to Anesthesia ? (Yes / No)

Social History:
Where and with whom are you living currently?

Relationship status: (married, separated, divorced, single?) Any Children?

Highest Level of Education/Current Employment:

Other information you feel would be relevant for us to know: