Pasadena Neuropsychiatry & TMS Center
595 E Colorado Blvd, Suite 602
Pasadena, Ca 91101
Phone: (626) 765-6704 Fax (415) 727-4781

New Potential Patient Form

Please fill in all the information as accurately as possible.

Date _____ ***Received by*** _____ ***Contact Type:*** ***Phone*** _____ ***Email*** _____

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

Cell Phone (____) _____ Home Phone (____) _____ email _____

REFERRED BY

Physician _____ Physician Name _____

Insurance _____ Insurance Carrier Name _____ Member ID _____

Other _____ Specify _____

REASON FOR SCHEDULING / HEALTH CONCERNS / SYMPTOMS

_____

_____

_____

_____

_____

Are you calling for TMS (Transcranial magnetic stimulation) Yes ___ No ___

SCRIPT / DISCLOSERS

- Do you currently feel safe? Do you have thoughts or plans for self harm or of harming others? Yes* _____ No _____
- Were you discharged from an ER or the hospital in the last 30 days? Yes_____ No _____
- Do you hear voices or take medications for hearing voices? (If yes, name of medication (s) Yes _____ No _____
- Have been pregnant in the last 12 months? Yes _____ No _____
- Do you currently see a psychiatrist or have you in the past? If yes, name._____Yes _____ No _____
- Current medications (all medications):_____

  _____
- Previous Psychiatric medications if any _____

  _____
- What attributes are you hoping to find in a psychiatrist? _____

  _____