

Wayne Behavioral Service, LLC

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Prior Treatment History

We are happy to provide the consultation for you and to discuss available treatment options for your condition.

In order for us to have the most productive consultation and recommendations, we would very much welcome any and all information you can provide about your condition at the time of the consultation if at all possible. You might not remember all the details however sometimes consulting others who are familiar with your condition (family members or friends), your prior records as well as pharmacy refill records can help complete the list.

Please take a few minutes to complete the following prior treatment questionnaire. Check the medications you have tried, and in the comments include dosage and approximate length of treatment and outcome.

A. Name & location of referring and/or current psychiatrist: _____

B. Date current episode began: _____

C. MEDICATION TREATMENT:

Medication Class & Examples	Dates Taken (mo/year-mo/year)	Highest Dosage	Side Effects, Reason for Discontinuation, etc.	Current or Lifetime
1. SSRI's (Selective Serotonin Reuptake Inhibitors):				
<input type="checkbox"/> Prozac (Fluoxetine)				
<input type="checkbox"/> Zoloft (Sertraline)				
<input type="checkbox"/> Paxil (Paroxetine)				
<input type="checkbox"/> Celexa (Citalopram)				
<input type="checkbox"/> Lexapro (Escitalopram)				
<input type="checkbox"/> Luvox (Fluvoxamine)				
2. SNRI's (Selective Serotonin & Norepinephrine Reuptake Inhibitors):				
<input type="checkbox"/> Effexor (Venlafaxine)				
<input type="checkbox"/> Pristiq (Desvenlafaxine)				
<input type="checkbox"/> Cymbalta (Duloxetine)				
3. Atypical Antidepressants:				
<input type="checkbox"/> Wellbutrin (Bupropion)				
<input type="checkbox"/> Remeron (Mirtazepine)				
<input type="checkbox"/> Serzone (Nefazadone)				
<input type="checkbox"/> Trazadone (Desyrel)				
<input type="checkbox"/> Viibryd				
<input type="checkbox"/> Trintellix				
<input type="checkbox"/> Fetzima				
4. Tricyclic Antidepressants:				
<input type="checkbox"/> Elavil (Amitriptyline)				
<input type="checkbox"/> Tofranil (Imipramine)				
<input type="checkbox"/> Pamelor (Nortriptyline)				
<input type="checkbox"/> Norpramin (Desipramine)				
<input type="checkbox"/> Aventyl (Protriptyline)				
<input type="checkbox"/> Asendin (Amoxapine)				
<input type="checkbox"/> Ludiomil (Maprotyline)				
<input type="checkbox"/> Other: _____				

Medication Class & Examples	Dates Taken (mo/year-mo/year)	Highest Dosage	Side Effects, Reason for Discontinuation, etc.	Current or Lifetime
5. Monoamine Oxidase Inhibitors (MAOIs):				
<input type="checkbox"/> Nardil (Phenelzine)				
<input type="checkbox"/> Parnate				
<input type="checkbox"/> Emsam patches				
6. Atypical Antipsychotics:				
<input type="checkbox"/> Abilify				
<input type="checkbox"/> Seroquel				
<input type="checkbox"/> Rexulti				
7. Mood Stabilizers:				
<input type="checkbox"/> Lithium				
<input type="checkbox"/> Depakote				
<input type="checkbox"/> Tegretol				
<input type="checkbox"/> Trileptal				
<input type="checkbox"/> Lamictal (Lamotrigine)				
<input type="checkbox"/> Other _____				
8. Augmentation				
<input type="checkbox"/> Thyroid supplements (Synthroid, Levoxyl, Cytomel, Armour thyroid, etc.)				
<input type="checkbox"/> Psychostimulants (Ritalin, Adderall, Dexedrine, Vyvanse, Provigil, Nuvigil)				
<input type="checkbox"/> Buspar (Buspirone)				
<input type="checkbox"/> Deplin (L-Methylofolate)				
<input type="checkbox"/> Other _____				

D. PSYCHOTHERAPY:

<input type="checkbox"/> Supportive <input type="checkbox"/> Cognitive Behavioral (CBT) <input type="checkbox"/> DBT <input type="checkbox"/> EMDR Other (please specify): _____	Name & Location of Therapist:
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E. Electro Cortical Therapy (ECT, Shock therapy):

Comments _____

F. Prior Transcranial Magnetic Stimulation (TMS):

Comments _____

G. Psychiatric admissions or Partial Hospital Treatment:

Comments _____

H. Prior Spravato or Ketamine Treatment:

Comments _____

I. How did you hear about us? _____

