TREATMENT HISTORY CHECKLIST

Patient Name: _____ **Date:** _____

DOB: _____

Have you tried?				What Happened?
Brintellix	(Vortioxetine)	**Yes**	**No**	_____
Fetzima	(Levomilnacipran) (SNRI)	**Yes**	**No**	_____
Viibryd	(Vilazodone) (SSRI)	**Yes**	**No**	_____
Celexa	(Citalopram) (SSRI)	**Yes**	**No**	_____
Lexapro	(Escitalopram) (SSRI)	**Yes**	**No**	_____
Prozac	(Fluoxetine) (SSRI)	**Yes**	**No**	_____
Luvox	(Fluvoxamine) (SSRI)	**Yes**	**No**	_____
Paxil	(Paroxetine) (SSRI)	**Yes**	**No**	_____
Zoloft	(Sertraline) (SSRI)	**Yes**	**No**	_____
Elavil	(Amitriptyline)	**Yes**	**No**	_____
Pristiq	(Desvenlafaxine) (SNRI)	**Yes**	**No**	_____
Cymbalta	(Duloxetine) (SNRI)	**Yes**	**No**	_____
Effexor	(Venlafaxine) (SNRI)	**Yes**	**No**	_____
Remeron	(Mirtazapine)	**Yes**	**No**	_____
Wellbutrin	(Bupropion)	**Yes**	**No**	_____

Individual or Group Therapy: _____

Any metal in or around the head: **Yes** **No**

Prior TMS: **Yes** **No**

Prior ECT: **Yes** **No**