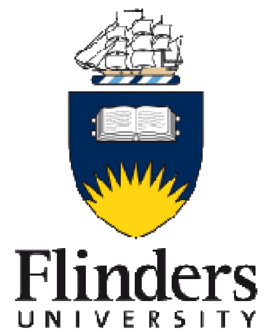

Applied Brain Research Laboratory

Screening Questionnaire for Transcranial Magnetic Stimulation and Transcranial Direct Current Stimulation

Last Name:

First Name:

Date of Birth:

Please take the time to answer the following questions.

	Yes	No
1. Do you have epilepsy or have you ever had a convulsion or seizure?	☐	☐
2. Does anyone in your family suffer from epilepsy?	☐	☐
3. Have you ever had a fainting spell or syncope? If yes, please describe on which occasion(s).	☐	☐

Please enter text here

	Yes	No
4. Have you ever had a head trauma that was diagnosed as concussion or was associated with loss of consciousness or a serious head injury?	☐	☐
5. Do you suffer from recurring headaches?	☐	☐
6. Have you ever had any head or brain surgery?	☐	☐
7. Do you have any hearing problems or ringing in your ears?	☐	☐
8. Do you have cochlear implants?	☐	☐

For use with single-pulse TMS, paired-pulse TMS or repetitive TMS, adapted from the "Safety, Ethical Considerations and Application guidlines for the use of transcranial Magnetic Stimulation" (Rossi et al. Clinical Neurophysiology 120 (2009)

	Yes	No
9. Are you pregnant or is there any chance you might be?	☐	☐
10. Do you have metal in the brain, skull or elsewhere in your body (e.g. splinters, fragments, clips, etc) except titanium?	☐	☐
11. Do you have an implanted neurostimulator (e.g. DBS, epidural/subdural,VNS)?	☐	☐
12. Do you have a cardiac pacemaker or intracardiac lines or a medical infusion device?	☐	☐
13. Do you, or have you ever suffered from a sleep disorder?	☐	☐
14. Do you suffer from heart disease or had heart surgery?	☐	☐
15. Are you taking any medications? (please list on next page)	☐	☐
16. Have you had any other brain-related condition or illness that caused brain injury?	☐	☐
17. Do you suffer from any neurological or other medical conditions?	☐	☐
18. Did you ever undergo TMS in the past? If so, were there any problems?	☐	☐
Please enter text here		
19. Did you ever undergo MRI in the past? If so, were there any problems?	☐	☐
Please enter text here		

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Please indicate if you are currently taking any of the following medications and your current dosage.

Medication (generic)	Medication (brand or tradename)	Currently on this medication (please tick)	Current Dosage
Amantadine	Symmetrel®	☐	Please enter dosage
Alprazolam	Xanax®	☐	Please enter dosage
Baclofen	Pacifen®	☐	Please enter dosage
Benztropine	Benztrop® (tab) Cogentin® (injection)	☐	Please enter dosage
Carbamazepine	Tegretol® Teril®	☐	Please enter dosage
Citalopram	Celapram® Arrow-citalopram® Citalopram-Rex® Cipramil®	☐	Please enter dosage
Clobazam	Frisium®	☐	Please enter dosage
Clonazepam	Rivitril® (oral drops & injection) Paxam® (oral)	☐	Please enter dosage
Fluoxetine	Fluox® Prozac®	☐	Please enter dosage
Gabapentin	Neurontin® Nupentin®	☐	Please enter dosage
Haloperidol	Haldol® (injection) Serenace®	☐	Please enter dosage
Hyoscine	Scopaderm® (patch) Buscopan®	☐	Please enter dosage
Ketamine		☐	Please enter dosage
Lamotrigine	Lamictal® Arrow-lamotrigine® Mogine®	☐	Please enter dosage

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Levodopa + benserazide	Madopar®	☐	Please enter dosage
Levodopa + carbidopa	Sinemet®	☐	Please enter dosage
Lisuride	Dopergin®	☐	Please enter dosage
Lorazepam	Ativan® Lorapram®	☐	Please enter dosage
Mirtazapine	Remeron® Avanza® Zispin®	☐	Please enter dosage
Methylphenidate	Ritalin®	☐	Please enter dosage
Moclobemide	Apo-moclobemide® Aurorix®	☐	Please enter dosage
Paroxetine	Loxamine® Aropax®	☐	Please enter dosage
Pergolide	Permax®	☐	Please enter dosage
Phenytoin	Dilantin®	☐	Please enter dosage
Quetiapine	Seroque® Quetapel®	☐	Please enter dosage
Selegiline	Apo-selegiline® Eldepryl®	☐	Please enter dosage
Sertraline	Zoloft®	☐	Please enter dosage
Sodium valproate	Epilim®	☐	Please enter dosage
Temazepam	Normison® Euhypnos®	☐	Please enter dosage
Tolcapone	Tasmar®	☐	Please enter dosage
Topiramate	Topamax®	☐	Please enter dosage
Triazolam	Hypam® Halcion®	☐	Please enter dosage
Venlafaxine	Efexor®	☐	Please enter dosage
Vigabatrin	Sabril®	☐	Please enter dosage

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Please list any additional medications, including the dose.

Please enter details here

Please outline any neurological or medical conditions you have.

Please enter details here

Participant	Researcher
Name:___________________	Name:___________________
Signature:________________	Signature:________________
Date:____________________	Date:____________________

For use with single-pulse TMS, paired-pulse TMS or repetitive TMS, adapted from the "Safety, Ethical Considerations and Application guidlines for the use of transcranial Magnetic Stimulation" (Rossi et al. Clinical Neurophysiology 120 (2009)

Other information:

Please enter any relevant additional information here

Include ☐ Exclude ☐

Study Physician________________ Researcher ________________

Signed_______________________ Signed_______________________

Date_________________________ Date_________________________

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