Appendix A

TMS Screening Questionnaire

Date:_____ Participant ID:_____ Researcher: _____

Your responses to the following questions will be used solely for assessing your eligibility for participation in a TMS study. Additional details about the study are described in the informed consent form. To maximize safety, please answer the questions below. Please do not hesitate to ask any questions you may have regarding the items below. If you are not comfortable disclosing any of the required information, please inform the researcher that you do not wish to take part in the study. Your privacy will be respected, and after this documentation is analyzed, it will be destroyed.

1. YES / NO – Are you younger than eighteen years old?
2. YES / NO – Do you have a pacemaker?
3. YES / NO – Do you have any metal/electrical/magnetic implanted in your body except dental fillings?
4. YES / NO –Are you or could you possibly be pregnant?
5. YES / NO – Do you have any major medical problems or unstable medical problems?
6. YES / NO – Do you have any history of neurological or psychiatric illness?
7. YES / NO – Have you had any head injury or head surgery?
8. YES / NO –Experience frequent headaches or migraine?
9. YES / NO – Do you or any blood relatives (grandparent, parent, aunt/uncle, sibling, self) have a history of a seizure? If so, please circle all that apply.
10. YES / NO – Have you had unusual responses, e.g. faint when you go to the hospital or get blood drawn?
11. YES / NO – Are you currently taking any prescription or non-prescription medications(e.g. antihistamines, antibiotics) or use street drugs? If so, please discuss the exact medications you are taking with the researcher.
12. YES / NO – Have you taken any antibiotics in the past week?
13. YES / NO – Have you taken any medication other than contraceptives in the past 12 hours?
14. YES / NO – Have you used alcohol, nicotine, or drugs in the past 12 hours?
15. YES / NO – Have you experienced sleep deprivation within the past 48 hours?
16. YES / NO –Do you have any metal on your body (e.g. watch or jewelry, hair holders or pins, eye glasses, body piercings, wallet, keys?) If so, please remove.
17. YES / NO – Did you ever undergo TMS in the past?
18. YES / NO – Did you ever undergo MRI in the past?

Participant signature: _____ Date:_____

Researcher signature: _____ Date:_____