P.I._______

Participant

TMS Safety Screening Form

Name: ______________________________ Phone #: ______________________________

DOB: ______/_______/________ Email: _________________________________

Age: ______ Handedness: R / L / A

Gender: M / F

Please answer the following questions:

Question	
Do you have any metal in your head (outside of the mouth), such as shrapnel, surgical clips, or fragments from welding or metalwork?	**Y / N**
Do you have any implanted devices such as cardiac pacemakers, medical pumps, intracardiac lines, neurostimulators or cochlear implants?	**Y / N**
Are you wearing any external items on your head such as a hearing aid, hair clip, hairpiece, wig or toupee?	**Y / N**
Have you ever had a head injury?	**Y / N**
Have you ever had neurosurgery?	**Y / N**
Have you ever had any illness that caused brain injury?	**Y / N**
Have you ever had a stroke?	**Y / N**
Do you suffer from frequent or severe headaches?	**Y / N**
Have you ever had a seizure? (Including febrile seizures as an infant)	**Y / N**
Does anyone in your family have epilepsy?	**Y / N**
Have you ever had an EEG?	**Y / N**
Have you ever been diagnosed with a neurological or psychiatric disorder?	**Y / N**

Have you ever had any other brain-related condition?	**Y / N**
Is there any possibility that you are currently pregnant?	**Y / N**
Are you taking any regular medications, or have you taken any drugs or medications within the last 72 hours?	**Y / N**
Have you ever had an adverse reaction to TMS?	**Y / N**
Do you need further explanation of TMS and its associated risks?	**Y / N**

Do you have any questions or concerns pertaining to your participation and safety?

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Participant signature **Date/ Session ID**

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Investigator signature