TMS screening questionnaire based on the latest safety guidelines consensus paper (Rossi et al., 2009). According to the consensus guidelines, "Affirmative answers to one or more of questions 1-18 do not represent absolute contraindications to TMS, but the risk/benefit ratio should be carefully balanced by the Principal Investigator of the research project or by the responsible (treating) physician." For this study, however, we will treat questions 1-18 as absolute contra-indications, such that any subject providing an affirmative answer to any of these questions will be excluded from participation.

TMS Screening Questionnaire

1. Do you have epilepsy or have you ever had a convulsion or seizure?
□ yes □ no

2. Do you have a family history of epilepsy, convulsions, or seizure?
□ yes □ no

3. Do you suffer from migraine headaches?
□ yes □ no

4. Do you suffer from trigeminal neuralgia or other type of neuropathic pain?
□ yes □ no

5. Have you ever suffered from encephalitis or meningitis?
□ yes □ no

6. Have you ever had a fainting spell or syncope?
□ yes □ no

7. Have you ever had severe (i.e. followed by a loss of consciousness) head trauma?
□ yes □ no

8. Do you have any hearing problems or ringing in your ears?
□ yes □ no

9. Are you pregnant or is there any chance that you might be?
□ yes □ no

10. Do you have metal in your brain/skull other than titanium (e.g. splinters, fragments, staples, permanent retainers)?
□ yes □ no

11. Do you have cochlear implants?
□ yes □ no

12. Do you have an implanted neurostimulator (e.g. DBS, epidural/subdural, VNS)?
□ yes □ no

13. Do you have a cardiac pacemaker or intracardiac lines or metal in your body?
□ yes □ no

14. Do you have a medication infusion device?
□ yes □ no

15. Have you ever had any surgical procedures on your spinal cord?
□ yes □ no

16. Do you have spinal or ventricular deviations?
□ yes □ no

17. Are you allergic to BOTH aspirin and ibuprofen painkillers?
□ yes □ no

18. Are you taking any psychoactive medications, or drugs for the treatment of any neurological or psychiatric conditions?
□ yes □ no

Please list any drugs, medications, pills, or supplements you are currently taking:

_____

_____

_____

Name_____

Signature _____Date _____

Reviewed by: _____Date _____