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| **Questionnaire before the experiment.**  Instruction. Please fill in completely and legibly. Please always mark the answer with a cross. |

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| 1. Age: |  |
| 1. Sex: | M  F |
| 1. Date of birth (DD/MM/YYYY): |  |
| 1. How many years have you spent in school, training and university? (in years): |  |
| 1. Did you already participat in another experiment with electrical or magnetic stimulation? | YES  NO |
| 1. Are you currently participating in another experiment? | YES  NO |
| 1. Do you experience headaches? | YES  NO  If so, how often do you experience headaches?  Every day  Several times a week  Once a week  Several times per month  Less than once a month  Please indicate how intense your headaches are!  (1 = low - 10 = unsustainable): |

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| **Questionnaire for the first session.**  Instruction. Please fill in completely and legibly. Please always mark the answer with a cross. | |
| 1. **Before the session.** | |
| 1. How many hours did you sleep last night? |  |
| 1. Please estimate how well you slept on a scale from 1 to 5!   (1: very bad - 5: very good) | 1 2 3 4 5 |
| 1. How many minutes did it take you to fall asleep? |  |
| 1. How many times did you wake up last night? |  |
| 1. Have you been drinking coffee today? | YES  NO  If yes, please state when you had your last coffee? |
| 1. Have you taken any medication in the last 24 hours? | YES  NO  If yes, please provide the names of the medications: |
| 1. Have you been drinking alcohol in the last 24 hours? | YES  NO  If yes, please state how much alcohol you have drunk:  little  moderate  much  very much |
| 1. How are you feeling right now? (1 = very tired - 10 = completely awake) | 1 2 3 4 5 6 7 8 9 10 |
| 1. Do you have a headache right now? | YES  NO  If so, how severe is your headache?  (1 = low - 10 = very high): |
| 1. Have you noticed any other anomalies? | YES NO  If yes, please call the experimenter. |

1. **After the session.**

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| 1. How are you feeling right now? (1 = very tired - 10 = completely awake) | 1 2 3 4 5 6 7 8 9 10 |
| 1. Did you notice any headaches during the task? | YES  NO  If so, how severe was your headache?  (1 = low - 10 = very high): |
| 1. Have you noticed any other anomalies? | YES  NO  If yes, please call the experimenter. |

Comments (to be filled in by staff)

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| **Questionnaire for meetings two to five.**  Instruction. Please fill in completely and legibly. Please always mark the answer with a cross. | |
| 1. **Before the session.** | |
| 1. How many hours did you sleep last night? |  |
| 1. Please estimate how well you slept on a scale from 1 to 5!   (1: very bad - 5: very good) | 1 2 3 4 5 |
| 1. How many minutes did it take you to fall asleep? |  |
| 1. How many times did you wake up last night? |  |
| 1. Have you been drinking coffee today? | YES  NO  If yes, please state when you had your last coffee? |
| 1. Have you taken any medication in the last 24 hours? | YES  NO  If yes, please provide the names of the medications: |
| 1. Have you been drinking alcohol in the last 24 hours? | YES  NO  If yes, please state how much alcohol you have drunk:  little  moderate  much  very much |
| 1. How are you feeling right now? (1 = very tired - 10 = completely awake) | 1 2 3 4 5 6 7 8 9 10 |
| 1. Do you have a headache right now? | YES  NO  If so, how severe is your headache?  (1 = low - 10 = very high): |
| 1. Have you noticed any other anomalies? | YES  NO  If yes, please call the experimenter. |

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| 1. **After the session.** | |
| 1. How are you feeling right now? (1 = very tired - 10 = completely awake) | 1 2 3 4 5 6 7 8 9 10 |
| 1. Did you notice any headaches during the task? | YES  NO  If so, how severe was your headache?  (1 = low - 10 = very high): |
| 1. Did your scalp tingling under the electrodes during stimulation? | YES  NO  - If so, how much did you feel the tingling?  1 = low - 10 = very strong: |
| 1. Did your scalp itch under the electrodes during stimulation? | YES  NO  If so, how badly did you feel the itching?  1 = low - 10 = very strong: |
| 1. Did your scalp burn under the electrodes during stimulation? | YES  NO  If so, how much did you feel the burning?  1 = low - 10 = very strong: |
| 1. Did you notice any light flickering during the task? | YES  NO  If so, how strong was this perception?  1 = low - 10 = very strong: |
| 1. Have you noticed any other anomalies? | YES  NO  If yes, please call the experimenter. |

Comments (to be filled in by staff)

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