**TACS Challenge Documents** V. 09/06/2025

**TES associated sensations questionnaire**

**To be asked and filled in by experimenter only** at the end of each block

|  |  |  |
| --- | --- | --- |
| Subject ID | Date (DD.MM.YYYY) | Time of day (HH:MM) |
|  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Block 1** | **Block 2** | **Block 3** | **Block 4** | **Block 5** | **Block 6** | **Block 7** | **Block 8** | **Block 9** | **Block 10** | **Block 11** | **Block 12** | **Block 13** |
| Block (sh/A/B/C) | sh |  |  |  | sh |  |  |  | sh |  |  |  | sh |
| **Do you see flashes/flickering of light?** | | | | | | | | | | |
| Yes/No |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rating (1-10) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Do you feel stimulation of the skin (burning/pickling/tingling etc)?** | | | | | | | | | | |
| Yes/No |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rating (1-10) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Do you feel rhythmic sensation on the skin?** | | | | | | | | | | |
| Yes/No |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rating (1-10) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Is the stimulation painful?** | | | | | | | | | | |
| Yes/No |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rating (1-10) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Do you have metal taste in the mouth?** | | | | | | | | | | |
| Yes/No |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rating (1-10) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Do you feel dizzy/nausea?** | | | | | | | | | | |
| Yes/No |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rating (1-10) |  |  |  |  |  |  |  |  |  |  |  |  |  |