**TACS Challenge Documents**

**TES associated perceptions questionnaire**

**To be asked and filled in by experimenter only**

|  |  |  |
| --- | --- | --- |
| 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(A/B/C) |  |  |  |  |  |  |  |  |  |
| **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) |  |  |  |  |  |  |  |  |  |