TMS ADVERSE EVENTS AND ASSOCIATED SENSATIONS QUESTIONNAIRE

The present questionnaire is intended to be administered by the experimenter at the end of each experimental session

Section I- Participant general information

To be filled for the first session only **Date** __ /__ /__

Laboratory ID _____

Study ID *(please, specify an unique code for the study)* _____

Experimenter ID _____

Subject ID *(please, specify an unique code for the subject)* _____

Subject's group *(when applicable):* Patients □ Healthy □

Sex: F □ M □ *Handedness*_____ **Age**__

Time of day of the stimulation: _ _:_ _

Neurological/psychiatric/cardiovascular/ other diseases: past □ current □ *please, specify*

_____

- *Did you ever have any sort of brain stimulation in the past?* Yes □ No □
- *If yes, how many sessions?* _____ *How long the stimulation lasted approximately?* _____ *When did you take part in this session?* _____
- *Did you experience any adverse effect?*
- *Did you ever have any brain or spinal cord surgery in the past?* Yes □ No □
- *If yes, when?* _____
- *Have you ever lost consciousness? If yes, how many times in the last year? Can you provide a brief description of the reason?* _____
- *How often do you drink alcohol?* _____
- *If so, how much do you drink per week?*
- *Are you a smoker?* _____
- *If so, how much do you smoke per week?*
- *Substance consumption Yes/Not*
- *If yes, which substances and when/how often?*

For patients only

*For which disease is the TMS applied?*_____

*Do you have any other disease?*_____

Did you experience a reduction/exacerbation of symptoms? If yes, what?

_____

Section II- Participant specific information

To be filled before each session

Experimental condition _____ **Subject ID** _____ **Study ID**_____
Date __ /__ /__

- *How much sleep did you get last night (hours)? _____, the quality of your sleep was good*□ inadequate □ *poor* □
- *Do you feel rested?*
- *Are you tired? (VAS)*
- *Last menstruation (if applicable)* _____ Do you assume any contraception or hormonal form? _____
- *Did you drink alcohol in the last 2 days? _____, if yes, what?_____ how much (please specify unit)? _____, within the last day? _____*
- *How many cigarettes did you smoke in the last 24 h, approximately? _____*
- *How many caffeine containing drinks (coffee, energy drink, tea) did you drink in the last 24 h? _____ How many of these drinks on average do you drink per day? _____*
- *Are you taking any medication? _____ if yes, what?_____ last consumption_____*
- *Any other substance use _____, if yes, what _____ how many times did you take this substance in the last 24 h? _____, how many times did you take it in the last year, approximately? _____*
- *Has any Adverse Event occurred since the last visit? If yes fill out AE form (last section)*

Section III- Experimental protocol

If the experiment counts only one session or the same TMS parameters are used in each session (e.g., treatment) this part should be filled for the first session only. Please, fill this part whenever stimulation parameters differ from those used in the first session. If several protocols of stimulation are applied, please reprint this page, and fill it out for each applied protocol.

Subject ID _____ **Study ID**_____ **Date** __ /__ /__

Experiment: **Treatment** □ **Single session** □ **Multiple sessions** □

For multiple sessions or treatment: Number of the current Session _____ Total number of Sessions _____ Hours/days passed between the current session and the previous session _____

Protocol

TMS device (name) _____ monophasic TMS □ biphasic TMS □

Online stimulation □ Offline stimulation □ Pulse width_____

*Coil size/code*_____: Figure 8 □ circular □ double cone coil □ H coil □

Parameters:

Single pulse □ rTMS □ patterned TMS □ Paired- TMS □

other □ (please. specify) _____

Number of pulses _____ Frequency _____ (interpulse interval) Number of trains _____ Intertrains interval _____ Intensity _____ (% of maximum stimulator output)

Total duration ____

Input/output curve □ intensities (%) _____; number of pulses for each intensity _____;

Please. specify the type of threshold: MEP □ contraction □ active motor threshold in left hand □ right hand □ Resting motor threshold in dominant hand □ Phosphenes □ Other (please, specify) □ _____ Intensity _____ (% of the motor/phosphenes threshold)

E-field TMS intensity evaluation □ please specify which software was used_____

Earplugs □ white noise □

Was the session completed □ prematurely terminated □ ? If prematurely terminated, specify the reason _____

Stimulation sites *(please specify)* _____

Please specify the exact coil position (and coordinate system) over the scalp _____

How was the correct position found? Individual MRI □ Template MRI □ 10/20 system □ MEP □ Phosphenes □ Other □ (please specify): _____

Please specify whether TMS was preceded by □ followed by □ contemporary to □ other NIBS (*e.g., tDCS, tACS*) _____

TMS was preceded by □ followed by □ contemporary to □ electroencephalography □ magnetic resonance □ cognitive training/task □ other (please, specify) _____

Section IV- Stimulation related sensations

To be filled after each session

Did you experience any of the following sensations? Please answer by inserting the number that corresponds to the degree of the experienced discomfort, with 0 (None), 1 (Mild), 2 (Moderate), 3 (Considerable), 4 (Strong). Please, specify when the sensation started and how long it lasted

		When did the sensations begin				*How long did it last*?				*Location*
	Degree (from 0 to 4)	At the beginning of the stimulation	In the middle of the stimulation	Towards the end of the stimulation	After the end of the stimulation	It stopped quickly	It stopped in the middle of the stimulation	It stopped at the end of the stimulation	it stopped after the end of the stimulation (duration in min)	(e.g., head, arm, finger) Diffuse/localised/close to stimulation
Scalp pain										
Toothache										
Tingling at scalp										
Tingling (peripheral nerves)										
Itching										
Burning or heat										
Headache										
Noise (e.g., tinnitus)										
Skin sensation										
Muscle contraction (excluding "targeted" MEPs)										
Fatigue										
Sleepiness										
Hearing changes										
Mood changes (depression)										
Mood changes (euphoria)										
Nausea										

Neck stiffness/pain										
Coil pressure										
Anxiety/ Nervousness										
Difficulty in concentrating										
Other (specify)										

- *These sensations (when applicable): 1. enhanced the task performance □; 2. hampered the performance □; 3. did not affect performance □*
- *If yes, how much?* Slightly □ considerably □ much □ very much □
- *Overall, your performance was enhanced □ hampered □ unchanged □ by the stimulation*
- *(For patients only) There has been any change in medication between sessions or in the last days?_____*

Optional

- *Do you believe that in the current session you received a real or placebo/sham stimulation?* Real □ placebo □ I don't know □
- *Do you believe you received a placebo stimulation? _____, If yes, in which session? _____*

Section V- Serious adverse events

To be filled only in case of SAE/AE

Please report any adverse event (AE)/problem (e.g., dizziness, seizure, paresthesia, syncope, insomnia, anxiety or others, please specify) that occurred and classify the event on a scale from 1 (Mild) to 4 (Strong) and, when possible, specify the frequency.
Please, if available report information on the following in the open box: duration of unconsciousness; eyes open/closed; muscle tone; falls; involuntary movements; number of contractions (e.g., myoclonic jerks, muscle twitches, cloni); duration of confusion; tongue biting; incontinence; headache; details on the background/ training of the experimenter

_____
_____
_____
_____

If available, report blood pressure _____ and heart rate _____ values after the AE.

Notes:

_____
_____
_____
_____