SCREENING QUESTIONNAIRE

FOR TRANSCRANIAL ELECTRICAL STIMULATION (TES)

Before tES, answer the following questions:

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|  |  | **YES** | **NO** |
| 1 | Do you have metal (except titanium) or electronic implants in the brain/skull (e.g., splinters, fragments, clips, cochlear implants, deep brain stimulation etc.)? If yes, please specify the type of metal and the location:  |  |  |
| 2 | Do you have metal or any electronic device at other sites in your body, such as a cardiac pacemaker or traumatic metallic residual fragments? If yes, please specify the device and the location: |  |  |
| 3 | Did you ever have surgical procedures involving your head or spinal cord? If yes, please specify the locations: |  |  |
| 4 | Have you ever had a head trauma followed by impairment of consciousness? |  |  |
| 5 | Do you have skin problems, such as dermatitis, psoriasis or eczema? If yes, please specify the location: |  |  |
| 6 | Do you have epilepsy or have you ever had convulsions, a seizure? |  |  |
| 7 | Did you ever have fainting spells or syncope? |  |  |
| 8 | Are you pregnant or is there any chance that you might be? |  |  |
| 9 | Are you taking any medications? If yes, please specify: |  |  |
| 10 | Did you ever undergo transcranial electric or magnetic stimulation in the past? If yes, were there any adverse events? Please specify: |  |  |

An affirmative answer to one or more of questions do not represent an absolute contraindication to tES, but the risk-benefit ratio should be carefully balanced by the Principal Investigator of the research project.

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SURNAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_