Informed consent – TMS

Before you are able to receive TMS treatment, we need to make sure that it is safe for you to do so. To that end, we need information about the possible factors that could enhance your risk to experience unintentional adverse effects. Please fill out the questionnaire carefully and honestly. This form will subsequently be assessed by a physician.

First- and last name:

_____

Please also sign at the bottom of each page

Gender:
male☐ female☐

Date of Birth:

_____

Phone number:

_____

Email address:

_____

Screening questionnaire

1) Do you have epilepsy? Yes ☐ No☐
If yes, please specify:

_____

2) Have you ever had a convulsion or a seizure? Yes ☐ No☐
If yes, please specify:

_____

3) Does someone in your family have epilepsy? Yes ☐ No☐
If yes, how are you related to this person?

_____

4) Have you ever lost consciousness without any known reason? Yes ☐ No☐
If yes, please describe when and how this occurred:

_____

5) Have you ever had a severe head trauma? Yes ☐ No☐
If yes, please specify:

6) Have you ever had a stroke? Yes ☐ No☐

If yes, please specify:

---

7) Have you ever undergone surgery to your head? Yes ☐ No☐
If yes, please specify:

---

8) Do you have any of the following implants in your body?:

(metal) Plates and/or screws	Yes ☐ No☐
Vascular clips	Yes ☐ No☐
Artificial Heart valve	Yes ☐ No☐
Metallic splinters/shrapnel/etc.	Yes ☐ No☐
Pacemaker	Yes ☐ No☐
Insulin pump	Yes ☐ No☐
Internal hearing aid (cochlear implant)	Yes ☐ No☐
Any other implant not mentioned above	Yes ☐ No☐

If you answered "yes" to any of the questions above, please specify:

---

9) Do you have any deviations of the spinal cord, bone marrow, or the ventricular system (spaces in the brain filled with liquid)? Yes ☐ No☐
If yes, please specify:

---

10) Do you have any hearing disabilities or ringing in your ears? Yes ☐ No☐
If yes, please specify:

---

11) Have you ever (at present or in the past) suffered from a brain-related, neurological illness? Yes ☐ No☐
If yes, please specify:

---

12) Do you suffer from frequent severe headaches? Yes ☐ No☐
If yes, please describe how often, and on which occasions:

---

13) Are you currently under any form of medical treatment? Yes ☐ No☐
If yes, please specify:

---

14) Are you currently taking antibiotics (a medication that helps alleviate bacterial infections)? Yes ☐ No☐

---

15) Do you ever take antihistamines (anti-allergy medication)? Yes ☐ No☐

If yes, how often and when was the last time you took them?

16) Are you taking any other medications not mentioned above? Yes ☐ No☐
If yes, please list:

17) Do you have a chronic illness/disorder? Yes ☐ No☐
If yes, please specify:

18) Have you ever (at present or in the past) had a psychiatric-based illness/disorder? Yes ☐ No☐
If yes, please specify:

19) Does someone in your family have a psychiatric-based illness/disorder? Yes ☐ No☐
If yes, please specify:

How are you related to this person?

20) Have you used any recreational drugs during the past year (such as marijuana, ecstasy, cocaine, etc.) Yes ☐ No☐
If yes, please specify which drugs did you use, and when was the last time that you used them?

22) Have you ever suffered from substance dependence or abuse? Yes ☐ No☐
If yes, please specify:

23) Do you averagely consume more than 3 alcoholic units a day? Yes ☐ No☐

24) Do you have sleeping problems? Yes ☐ No☐
If yes, please specify:

25) Are you pregnant, or is there a chance that you might be? Yes ☐ No☐

26) Have you ever undergone an MRI for clinical purposes? Yes ☐ No☐

If yes, did any problems occur during scanning? Yes ☐ No☐
If yes, please specify:

---

27) Have you ever undergone TMS? Yes ☐ No☐
If yes, have you ever had an adverse reaction to TMS? Yes ☐ No☐
If yes, please specify:

I answered all questions to the best of my knowledge and belief:

Signature ……

Date: …….. -…….. -……..…..