GSU/GT Center for Advanced Brain Imaging

831 Marietta St NW, Atlanta GA 30318

Phone (404) 385-8619

www.cabiatl.com

TRANSCRANIAL MAGNETIC STIMULATION SCREENING FORM

Transcranial Magnetic Stimulation (TMS) uses brief magnetic pulses to stimulate the brain cells near the scalp. There is a potential for the pulses to interact with nearby metal and/or electrical devices, thus we restrict any metal or electrical devices within one foot of the TMS coil. There is evidence that the TMS can induce fainting and, in rare cases, cause seizures. Therefore, participants with any history of epilepsy or seizure will be excluded. In addition, the system is loud, and participants will be provided hearing protection.

Yes	*No*	
☐	☐	Have you received Transcranial Magnetic Stimulation (TMS) before?
☐	☐	Have you had an adverse reaction to TMS? If yes, please describe _____
☐	☐	Do you have epilepsy or have you ever had a seizure?
☐	☐	Do you have any implanted devices such as a neurostimulator or cochlear implant?
☐	☐	Have you ever had a stroke or lesion (including tumor) in your brain?
☐	☐	Have you ever had a head injury or brain surgery?
☐	☐	Do you suffer from frequent or severe headaches?
☐	☐	Have you ever had a fainting spell or syncope?
☐	☐	Do you have any metal in your head such as shrapnel, surgical clips, or fragments from welding or metal work?
☐	☐	Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intra-cardiac lines?
☐	☐	Have you had any brain-related conditions? (i.e. multiple sclerosis, Parkinson's, Alzheimer's)
☐	☐	Have you ever had any illness that caused brain injury? (i.e. meningitis, aneurysm, brain tumor)
☐	☐	Have you ever had any head trauma that was associated with a loss of consciousness or diagnosed as a concussion?
☐	☐	Are you being treated for any psychiatric conditions (i.e. depression, anxiety, PTSD, schizophrenia)?
☐	☐	Have you had more than 2 cups of coffee/caffeinated beverages in the last 12 hours?
☐	☐	Have you had more than 2 alcoholic beverages in the last 12 hours?
☐	☐	Have you had less than 6 hours sleep in the last 24 hours?
☐	☐	Do you suspect that you might be pregnant?
☐	☐	Are you currently taking or recently stopped taking any medication or recreational drugs? If yes, please list_____
☐	☐	Do you need any further explanation of TMS and its associated risks?

Notes on any 'Yes' responses:

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the TMS procedure.

Name of Person Completing Form:_____

Signature of Person Completing Form:_____ Date (MM/DD/YYYY) _____

For Experimenter Use Only:

Name of Project & PI:_____

Researcher(s):_____

Person obtaining screening, Date, & Time:_____