

**Recruitment Screening Form**

This questionnaire shall be used to determine suitability of participation in the project. Please answer all questions honestly. All information shall be kept private and confidential.

Gender: F / M

Age: .

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| **TMS Stimulation** |  |
| Do you have epilepsy or have you ever had a convulsion or a seizure? | Yes / No |
| Do you have a family history of Epilepsy? | Yes / No |
| Have you ever had a Stroke? | Yes / No |
| Do you have Multiple Sclerosis? | Yes / No |
| Have you ever had a fainting spell or syncope? If yes, please describe on which occasion(s)? | Yes / No |
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| Have you ever experienced head trauma that was diagnosed as a concussion or was associated with loss of consciousness? | Yes / No |
| Do you have any hearing problems or ringing in your ears? | Yes / No |
| Do you have cochlear implants? | Yes / No |
| **[Women Only]** Are you pregnant or is there any chance that you might be? | Yes / No |
| **[Women Only]** Are you using any form of hormone based birth control? If so, please specify the type. | Yes / No |
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| Do you have metal in the brain, skull or elsewhere in your body (e.g., splinters, fragments, clips, etc.)? If so, please specify the type of metal. | Yes / No |
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| Do you have an implanted neurostimulator (e.g., DBS, Epidural/ Subdural, VNS)? | Yes / No |
| Do you have a cardiac pacemaker or intracardiac lines? | Yes / No |
| Do you have a medication infusion device? | Yes / No |
| Are you taking any medication? | Yes / No |
| Have you ever undergone TMS in the past? | Yes / No |
| If so, were there any problems. | Yes / No |
| Have you ever undergone an MRI Scan? | Yes / No |
| If so, were there any problems. | Yes / No |
| **Electrical Stimulation** |  |
| Do you have / ever had any form of heart condition? | Yes / No |
| Have you ever had an adverse effect to any form of electrical stimulation? | Yes / No |
| Do you have any allergies? If yes, please detail below. | Yes / No |
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| Do you maintain a regular sleep pattern? | Yes / No |
| Are you a recreationally active individual? | Yes / No |
| Do you have any other Medical Condition we should be informed about? If yes, please detail below. | Yes / No |
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I certify I have read, understood and completed the questionnaire above to the best of my knowledge.

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| Participants Name Participants Signature Date  (BLOCK CAPITALS |

Once complete, please return to: a.bullas@shu.ac.uk .

If you have any queries, comments or questions, please do not hesitate to get in contact: a.bullas@shu.ac.uk or +44 (0)7536044310.