**Participant Questionnaire for TMS Studies**

*The researchers wish to be inclusive in their recruitment process. This project requires:*

* *Young adults (18 – 40 years old)*
* *No balance, muscle, or nerve impairments*
* *No previous lower limb injury*
* *Have not previously suffered a stroke or brain injury*
* *No history of epilepsy*
* *No metal in head or body*

**Please complete the following questionnaire. The questionnaire will be used to identify exclusionary criteria. Please do not hesitate to ask any questions about the study or concerns you may have. You are able to withdraw from the study at any point without consequence.**

**Age:**

**Sex: Male or Female or Other**

1. Have you ever undergone Transcranial Magnetic Stimulation (TMS) before? Yes No

If yes, have you ever had an adverse reaction to TMS? Yes No

1. Do you suffer from any neurological or cutaneous (skin) disorders? Yes No

*If yes, please explain:*

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1. Do you suffer from any muscular disorders? Yes No

*If yes, please explain:*

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1. Have you ever had a concussion or symptoms of a concussion? Yes No

If yes, was it diagnosed by a doctor? Yes No

How long ago was this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has a doctor assessed you as ok to return to work and other activities? Yes No

1. Have you ever had a serious head injury that wasn’t diagnosed as a concussion? Yes No

If yes, were you assessed by a doctor? Yes No

Was it associated with a concussion like symptoms? Yes No

How long ago was this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have metal in the brain/skull (except titanium)? (eg splinter, fragments, clips etc) Yes No
2. Have you ever had a surgical procedure on your spinal cord or brain? Yes No
3. Have you ever had a fainting spell? Yes No
4. Have you occasionally had trouble sleeping? Yes No
5. Have you experienced unusual heartbeats such as skipped beats or palpitations? Yes No
6. Have you ever been told that your blood pressure was abnormal? Yes No
7. Do you suffer from diabetes? Yes No
8. Have you had any serious injury or surgery to your feet or lower limbs? Yes No

*If yes, please explain:*

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1. Have you ever experienced seizures, convulsions or fainting spells? Yes No
2. Is there any chance you may be pregnant? Yes No
3. Do you have any skin sensitivities or allergies? Yes No

*If yes, please explain:*

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1. Are you currently taking any of the following medications? PLEASE CIRCLE:

imipramine, amitriptyline, doxepine, nortriptyline, maprotiline, chlorpromazine, clozapine, foscarnet, ganciclovir, ritonavir, amphetamines, ketamine, gamma-hydroxybutyrate (GHB), theophylline. mianserin, fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, reboxetine, venlafaxine, duloxetine, bupropion, mirtazapine, fluphenazine, pimozide, haloperidol, olanzapine, quetiapine, aripiprazole, ziprasidone, risperidone, chloroquine, mefloquine, imipenem, penicillin, ampicillin, cephalosporins, metronidazole, isoniazid, levofloxacin, cyclosporin, chlorambucil, vincristine, methotrexate, cytosine arabinoside, BCNU, lithium, anticholinergics, antihistamines, sympathomimetics.

1. Have you or any member of your immediate family been treated for or suspected of having any of the following conditions? Please identify their relationship to you in the space provided (ie. yourself, father, mother etc.)

Relationship:

epilepsy Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

stroke Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

diabetes Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

heart disease Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

high blood pressure Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

memory loss Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

dementia Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hemophelia Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please indicate if you have any of the following:
   * cardiac pacemaker Yes No
   * aneurysm clips Yes No
   * implanted cardiac defibrillator Yes No
   * any type of biostimulator Yes No
   * any type of internal electrodes (cochlear implant) Yes No
   * insulin pump Yes No
   * any type of electronic, mechanical or magnetic implant Yes No
   * hearing aid Yes No
   * any type of surgical clip or staple Yes No
   * any implanted orthopaedic item (ie. pins, rods, screws, nails, clips, plates, wire) Yes No
2. Do you need further explanation of TMS and its associated risks?  **Yes No**

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

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Participant’s name (please print)

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Participant’s signature Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Witness’s signature Date:

Medication and Recreational Drug exclusionary list (for reference):

1. Intake of one or a combination of the following drugs forms a strong potential hazard for application of TMS due to their significant seizure threshold lowering potential: imipramine, amitriptyline, doxepine, nortriptyline, maprotiline, chlorpromazine, clozapine, foscarnet, ganciclovir, ritonavir, amphetamines, ketamine, gamma-hydroxybutyrate (GHB), theophylline. In these cases rTMS should be performed, when required, with particular caution.
2. Intake of one or a combination of the following drugs forms a relative hazard for application of TMS due to their significant seizure threshold lowering potential: mianserin, fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, reboxetine, venlafaxine, duloxetine, bupropion, mirtazapine, fluphenazine, pimozide, haloperidol, olanzapine, quetiapine, aripiprazole, ziprasidone, risperidone, chloroquine, mefloquine, imipenem, penicillin, ampicillin, cephalosporins, metronidazole, isoniazid, levofloxacin, cyclosporin, chlorambucil, vincristine, methotrexate, cytosine arabinoside, BCNU, lithium, anticholinergics, antihistamines, sympathomimetics. In these cases TMS should be performed, when required, with caution.
3. Withdrawal from one of the following drugs forms a strong relative hazard for application of TMS due to the resulting significant seizure threshold lowering potential: alcohol, barbiturates, benzodiazepines, meprobamate, chloral hydrate. In instances when withdrawal of these medications is clinically or scientifically indicated, TMS should be performed, if required, with caution.
4. Use of the following recreational drugs may increase the risk of injury due to the resulting significant seizure threshold lowering potential: alcohol, amphetamines, cocaine, (MDMA, ecstasy), phencyclidine (PCP, angel’s dust). In these cases TMS should be performed, when required, with particular caution.