York NeuroImaging Centre
THE UNIVERSITY of York

Safety Questionnaire and Consent for Participants

Version: 2 - 2014-04-01

Modality - TMS

Participant ID: R	**Surname:**	**Forename:**	**Date of Birth:**	**Contact No:**
Address		**GP Address**		
Verified		**Verified**		

If your, or your GP's, address are different to those shown above please cross out the old address and write the new one next to it. Please do not assume we will accept you for an experiment on the basis that you have participated in TMS elsewhere (regardless of whether it was for research or clinical reasons).
It is essential that all questions on this sheet are answered truthfully. This information is essential in order to ensure your safety and will be kept completely confidential. If you do not want to answer any question(s) on this form you are free to withdraw from this scanning session without any prejudice.

Please answer the following questions accurately by ticking the appropriate box. **Safety**	**Answer** Yes	No
Have you ever suffered from any neurological or psychiatric conditions?		
Have you ever suffered from epilepsy?		
Does anyone in your family (immediate or distant) suffer from epilepsy?		
Have you experienced febrile convulsions (fits associated with a high fever) at any time in your life?		
Have you ever suffered from a fit or a seizure?		
Have you fainted more than once?		
Have you fainted in the last 12 months?		
Have you ever suffered a head trauma that was diagnosed as a concussion or was associated with a loss of consciousness?		
Do you suffer from regular headaches or migraines?		
Do you suffer from anxiety?		
Are you feeling unduly anxious about the experiment today?		
Have you ever had any surgery on your head (including eyes), or spine?		
Do you have a cardiac pacemaker?		
Do you have any medication pumps?		
Do you have a cochlear implant?		
Do you have hearing problems or ringing in your ears?		
Are you currently taking any prescribed or un-prescribed medication other than the contraceptive pill?		
Are you currently undergoing anti-malarial treatment?		
Do you have any other bio-medical implants?		
Did you have very little sleep last night?		
Do you have any surgical clips?		
Have you ever had an injury to your eye(s) involving metal fragments?		
Are you, or could you be pregnant?		

Please answer the following questions accurately by ticking the appropriate box. **Safety**	**Answer** Yes	No
Have you already participated in a TMS or tDCS experiment today?		
Have you had more than 1 cup of coffee or other sources of caffeine, in the last hour?		
Have you drunk any alcohol today?		
Have you drunk more than 3 units of alcohol or used **any** recreational drugs in the last 24 hours?		

Consent

I understand that this questionnaire checks for serious risk factors		
I have fully understood and correctly answered all the questions on this form.		
If in any doubt please inform the Investigator before signing this form		
I have been fully informed and understand the nature of the procedure(s) to be carried out		
I have been able to ask questions regarding the procedure(s)		
I confirm that I give my full consent to the TMS procedure(s) being performed on me		
I am aware that I may end the procedure(s) at any time by informing a member of staff		

Signatures

Only sign if you are in **no doubt** about the participant's suitability for TMS

Project ID: -		**Date**
Participant (I confirm that I am over 18 years of age)		
Approved investigator	*Signature:*	
	Print Name:	
Approved operator	*Signature:*	
	Print Name:	