Family Care Center

DEEP TMS ADULT SAFETY SCREENING QUESTIONNAIRE

1. Have you ever had an adverse reaction to TMS?	☐ NO	☐ YES
2. Have you ever had a seizure?	☐ NO	☐ YES
3. Have you ever had an EEG?	☐ NO	☐ YES
4. Have you ever had a stroke?	☐ NO	☐ YES
5. Have you ever had a head injury (include neurosurgery)?	☐ NO	☐ YES
6. Do you have any metal in your head (outside of the mouth) such as shrapnel, surgical clips, or fragments from welding or metalwork?	☐ NO	☐ YES
7. Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intracardiac lines?	☐ NO	☐ YES
8. Do you suffer from frequent or severe headaches?	☐ NO	☐ YES
9. Have you ever had any other brain-related condition?	☐ NO	☐ YES
10. Have you ever had any illness that caused brain injury?	☐ NO	☐ YES
11. Are you taking any medications?	☐ NO	☐ YES
12. If you are a woman of childbearing age, are you sexually active, and if so, are you using a reliable method of birth control?	☐ NO	☐ YES
13. Does anyone in your family have epilepsy?	☐ NO	☐ YES
14. Do you need further explanation of TMS and its associated risks?	☐ NO	☐ YES

NOTE: A positive screen is any "YES" answer and indicates further investigation by the clinician (but not indicating exclusion from TMS).

Name: _____ Date: _____

Family Care Center
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