Form 32: Transcranial Magnetic Stimulation Adult Safety Screen (TASS)

1	Have you ever had an adverse reaction to rTMS?	☐ 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 (including 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 woman of childbearing age, are you sexually active, and if so, are you *not 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 rTMS and its associated risks?	☐ No ☐ Yes
15	If any item was marked 'yes', please provide a comment here:	