

# Questionnaire of sensations related to transcranial electrical stimulation (TES)

*(To be filled in by the participants and by the investigator)*

**Investigator:**

**Participant name/code:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**Experiment/Treatment:** \_\_\_\_\_

**No stimulations experienced before**  **Experienced**  # of stimulations sessions before:

.....

**Type of electrical stimulation used here** \_\_\_\_\_ **Intensity** \_\_\_\_\_ mA (if known)

**Electrodes dimension:** anode (if known) \_\_\_\*\_\_\_ cathode (if known) \_\_\_\*\_\_\_ (shape \_\_\_\_\_)

other \_\_\_\_\_

**Participant:**

Did you experience any discomfort during the electrical stimulation? Please indicate the degree of intensity of your discomfort according to the following scale:

- **None** = I did not feel the sensation addressed
- **Mild** = I mildly felt the sensation addressed
- **Moderate** = I felt the sensation addressed
- **Strong** = I felt the sensation addressed to a considerable degree

*In the first stimulation block I felt (to be filled in by subject, if it is possible please separate the sensations with regard to the electrode positions):*

|                             | <i>None</i>              | <i>Mild</i>              | <i>Moderate</i>          | <i>Strong</i>            |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Itching                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Warmth/Heat                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Metallic/Iron taste         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue/Decreased alertness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

In case of perceived sensation, when did it begin? *(this part can be multiplied and completed for each sensation, e.g. one for pain, one for itching etc and could/should be modified according to the type of experiments)*

At the beginning;       At approximately in the middle;       Towards the end of the stimulation

Duration (multiple options allowed)

Only initially       It stopped in the middle of the block       It stopped at the end of the block

**How much did these sensations affect your general state?**

Not at all     Slightly     Considerably     Much     Very much

**Location of sensations:**

Diffuse    localized    close to the electrode, (which one?) \_\_\_\_\_;    Other \_\_\_\_\_

If you would like to provide more details, please briefly describe the experimented sensations in relation to the “Other” or “Fatigue” or ..... response:

**In the second stimulation block**

*(if there is more than one condition, repeat the list above here based on the block numbers)*

**To be administered at the end of the entire experiment**

Do you believe that you received a real or placebo stimulation?

In the first stimulation block/day/week:                       real                       placebo                       I don't know

In the second stimulation block/day/week:    real                       placebo                       I don't know

**Investigator:**

Please report any adverse event/problem (typically skin irritation and redness – separately for the electrodes -, headache, scalp pain, dizziness, or others, please specify) that occurred and rate the event/problem on a scale from 0 to 3 as previously described.

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Additional comments:

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A structured questionnaire on intensity and frequency of AEs increases safety, when transcranial electrical stimulation is used. It is a recommended procedure for publication of TES experiments/trials.