SCREENING QUESTIONNAIRE FOR TRANSCRANIAL ELECTRICAL STIMULATION (TES)

		YES	NO
1	Do you have metal (except titanium) or electronic implants in the brain/skull (e.g., splinters, fragments, clips, cochlear implants, deep brain stimulation etc.)? If yes, please specify the type of metal and the location _____ _____		
2	Do you have metal or any electronic device at other sites in your body, such as a cardiac pacemaker or traumatic metallic residual fragments? If yes, please specify the device and the location _____		
3	Did you ever have surgical procedures involving your head or spinal cord? If yes, please specify the locations _____		
4	Have you ever had a head trauma followed by impairment of consciousness?		
5	Do you have skin problems, such as dermatitis, psoriasis or eczema? If yes, please specify the location _____		
6	Do you have epilepsy or have you ever had convulsions, a seizure?		
7	Did you ever have fainting spells or syncope?		
8	Are you pregnant or is there any chance that you might be?		
9	Are you taking any medications? If yes, please specify: _____		
10	Did you ever undergo transcranial electric or magnetic stimulation in the past? If yes, were there any adverse events? Please specify: _____		

An affirmative answer to one or more of questions do not represent an absolute contraindication to TES, but the risk-benefit ratio should be carefully balanced by the Principal Investigator of the research project or by the responsible (treating) physician.

Name _____ Surname _____

Date _____ Signature _____