TMS Adult Safety Screen Questions

Please circle either yes or no to the following questions:

1. Have you ever had an adverse reaction to TMS? Yes or No
2. Have you ever had a seizure? Yes or No
3. Have you ever had a stroke? Yes or No
4. Have you ever had a head injury or neurosurgery? Yes or No
5. Do you have metal in your head (outside your mouth) such as shrapnel, surgical clips, or fragments from metal work? Yes or No
6. Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intracardiac lines? Yes or No
7. Do you suffer from frequent or severe headaches? Yes or No
8. Do you suffer from other brain-related condition? Yes or No
9. Have you had any illness that caused brain injury or damage? Yes or No
10. Are you taking any medications? Yes or No
11. For women of childbearing age: If you are sexually active are you not using reliable birth control? Yes or No
12. Does anyone in your family have epilepsy? Yes or No

If you answer yes to any questions, further exploration by a TMS Physician should be done.

Clinician Signature: ______________