GREATER LOWELL PSYCHIATRIC ASSOCIATES, LLC 73 PRINCETON STREET, SUITE 203 NORTH CHELMSFORD, MA 01863
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TRANSCRANIAL MAGNETIC STIMULATION (TMS) ADULT SAFETY SCREEN

Date: _____ Patient Name: _____ D.O.B: _____

Please answer the following questions:

1. Have you ever had an adverse reaction to TMS?	☐Yes ☐ No
2. Have you ever had a convulsion or a seizure?	☐Yes ☐ No
3. Have you ever had a stroke?	☐Yes ☐ No
4. Have you ever had a head injury or neurosurgery?	☐Yes ☐ No
5. Do you have metal in your head (outside your mouth) such as shrapnel, surgical clips, or fragments from metal work?	☐Yes ☐ No
6. Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intracardiac lines?	☐Yes ☐ No
7. Do you suffer from frequent or severe headaches?	☐Yes ☐ No
8. Do you suffer from any other brain-related condition(s)?	☐Yes ☐ No
9. Have you had any illnesses that caused brain injury?	☐Yes ☐ No
10. Are you taking any medication?	☐Yes ☐ No
11. For women of childbearing age: are you pregnant or any chance that you may be?	☐Yes ☐ No
12. Does anyone in your family have epilepsy?	☐Yes ☐ No
If any item was marked “Yes”, please provide an explanation in the space below:	

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

Clinician Signature: _____ Date: _____