Consent Form for Treatment Course of Transcranial Magnetic Stimulation

TMS Screening Questionnaire

Patient Initials:_____ Date: _____/_____/_____

Please mark Yes or No for each question

	Yes	No
Do you have epilepsy or have you ever had a convulsion or a seizure?	☐	☐
Have you ever had a fainting spell (syncope)?	☐	☐
Have you ever had a head trauma that was diagnosed as a concussion or was associated with a loss of consciousness?	☐	☐
Do you have any hearing problems or ringing in your ears?	☐	☐
Do you have cochlear implants?	☐	☐
Are you currently pregnant?	☐	☐
Do you have any metal in the brain, skull or elsewhere in your body? This can include splinters, fragments, clips, etc. If yes, specify the type of metal. _____	☐	☐
Do you have a neurostimulator in your body? This can include a vagal nerve stimulator, deep brain stimulator, epidural/subdural stimulator, etc. If yes, specify the type of neurostimulator. _____	☐	☐
Do you have a cardiac pacemaker or intracardiac lines?	☐	☐
Do you have a medication infusion device?	☐	☐
Did you ever undergo TMS in the past? If yes, were there any problems? Describe below	☐	☐
Did you ever undergo an MRI in the past? If yes, were there any problems? Describe below.	☐	☐
Are you currently taking any medications, including over the counter medications? If yes, list below.	☐	☐

For any Yes response, please provide details below.

Please list all medications and please list any past neurological (relating to your brain or spinal cord) medical or surgical history.

_____

_____

_____

_____

_____

_____
_____

Participant Signature:_____ Date: _____/_____/_____

Print Name:_____

Provider Signature: _____Date: _____/_____/_____

Print Name:_____

Please complete, sign, and return this form to Strive prior to the start of the treatment course.