Report of abnormal or uncomfortable sensations during measurements

If your subject felt something that was uncomfortable, painful, or abnormal and surprising (*e.g.*, warming-up, numbness, dizziness etc.) during TMS-measurements, please, fill this form when applicable and return it as soon as possible to Aalto TMS office (Otakaari 5 I, 2nd floor, room IM213 or IM212). If necessary, you can add additional handwritten appendices to this report.

Measurement date:		Measurement time:	
Subject identification:			
Used TMS-coil (Air cooled, 9925 nr.1 or nr.2):			
Used TMS-stimulator (Rabid, BiStim):			
Stimulation area:		Number of pulses:	
Stimulaation intensity (%):		Stimulation frequency (rTMS):	
Other information:			
Subject age:	Sex:	Weight:	Height:

Subject's description of the abnormal and/or uncomfortable sensations (as detailed as possible):

Was there any abnormalities in the MR images (neuronavigation) :

Were these sensations ceased when the measurement was finished:

Did the subject abort the measurement because of these sensations:

How does the subject judge the level of uncomfortableness related to the sensations (on a scale from 1 to 10, where 1= not uncomfortable at all and 10 = extremely uncomfortable):

Aalto University
School of Science
Aalto TMS

Postal Address
P.O. BOX 13000
00076 AALTO

Street Address
Otakaari 5 I
Espoo

Contacts
+358 (0)50 4371613
aaltotms -sci@aalto.fi

How does the subject judge the level of pain related to the sensations (on a scale from 1 to 10, where 1 = not painful at all and 10 = extremely painful): _____

Was there any metal (prostheses, clips, jewelry etc.), tattoos or permanent makeup near the stimulation area: _____

Was the subject's hearing protected during the measurement (ear plugs.): _____

What kind of stimulus hardware/equipment was used additional to TMS during the measurement: _____

Were there any other devices used, which or whose wires were installed/mounted on the subject(EEG/EMG or custom devices): _____

Were there any "yes" or "don't know" answers in the safety screening form that the subject filled? Please, list all the "yes" or "don't know" answers here: _____

What was subject's health like before the measurement (did she/he have, *e.g.*, sniffle, fever, sickliness, any pains etc.): _____

Any other comments or observations: _____

Date:	
Printed name of the principal investigator:	
Signature of the principal investigator:	
Contact information:	