GSU/GT Center for Advanced Brain Imaging

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TRANSCRANIAL DIRECT CURRENT STIMULATION SCREENING FORM

Transcranial Direct Current Stimulation (tDCS) uses a low level of electrical current to stimulate the brain cells near the scalp. There is potential for the current to interact with nearby mental and/or electrical devices, thus we restrict any metal or electrical devices within one foot of the path of the current. The most commonly reported side effects are skin irritation, itching/ tingling sensation, visual flashes of light, mild headache, nausea, dizziness, and a metallic taste at the end of stimulation session. Headaches and skin irritations have been reported to last 24-72 hours. In addition, minor burns have occurred.

Yes	*No*	
☐	☐	Have you had an adverse reaction to tDCS?
☐	☐	Have you ever had a seizure (epilepsy)?
☐	☐	Has anyone in your family been diagnosed with epilepsy?
☐	☐	Have you ever had an Electroencephalogram (EEG)?
☐	☐	Have you ever had a stroke?
☐	☐	Have you ever experienced any head injury or undergone Neurosurgery?
☐	☐	Do you suffer from frequent or severe headaches?
☐	☐	Do you have any metal in your head such as shrapnel, surgical clips, or fragments from welding or metal work?(outside of your mouth)
☐	☐	Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intra-cardiac lines?
☐	☐	Have you had any brain-related conditions?
☐	☐	Have you ever had any illness that caused brain injury?(i.e. meningitis, aneurysm, brain tumor)
☐	☐	Have you had unstable severe disease such as cardiologic, pulmonary, renal, endocrinal (hyperthyroidism or hypothyroidism), gastrointestinal, or others?
☐	☐	Are you currently taking any medication? If yes, please list._____
☐	☐	Do you have a latex allergy?
☐	☐	If you are woman of childbearing ages; do you suspect that you might be pregnant?
☐	☐	Do you need any further explanation of tDCS and its associated risks?
☐	☐	If any item was marked "yes"' please provide a comment here:_____

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form:_____ Date (MM/DD/YYYY) _____

Form Completed By: ☐ Participant ☐ Relative

_____ _____

If relative, print your name State your relationship to participant

Notes to any checked items:

June 2020

For Experimenter Use Only:

Name of Project & PI: _____

Researcher(s):_____

Person obtaining screening, Date, & Time: _____