**Before Stimulation Questionnaire**

Subject Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Session #: \_\_\_\_\_\_\_\_\_\_\_\_

**Please complete this questionnaire prior to the start of stimulation.** It shouldn’t take long but take all the time you need.

Please describe if you experienced any of the side effects listed below that appeared AFTER your last treatment session. If none, please write "none".

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the PERSISTENCE of any of the side effects listed below which you indicated you experienced during or immediately following your last stimulation session.

Only include side effects which you continued to experience for at least 20 minutes after the session and include the duration.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| skin tingling | skin itching | skin burning | nauseous |
| diffuse or migraine-like headache | facial muscle twitching | blurred vision | short-lived, localized head pain or pressure |
| forgetfulness | difficulty concentrating | dizziness | difficulty breathing |

**After Stimulation Questionnaire**

Subject Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Session #: \_\_\_\_\_\_\_\_\_\_\_\_

**Please complete this questionnaire after the end of stimulation.** It shouldn’t take long but take all the time you need.

Listed below are several questions. Please mark clearly which of the choices apply most to you for each question. If you are confused about this or have any questions, feel free to ask the examiner to clarify.

Please describe in a few sentences your subject experiences **DURING** stimulation. Please be as descriptive as possible and include any feelings and changes in mental states.

|  |  |  |  |
| --- | --- | --- | --- |
| As a result of the present treatment session please indicate with an "x" if you experienced any of the below side effects. If so, then rate the intensity (1 - 10) and duration of the effect. | **Occurrence** | **Intensity** | **Duration (minutes)** |
| 1 = minimal |
| 4 = mild |
| 8 = moderate |
| 10 = severe |
| skin tingling |  |  |  |
| skin itching |  |  |  |
| skin burning |  |  |  |
| nauseous |  |  |  |
| diffuse or migraine-like headache |  |  |  |
| facial muscle twitching |  |  |  |
| blurred vision |  |  |  |
| short-lived, localized head pain or pressure |  |  |  |
| forgetfulness |  |  |  |
| difficulty concentrating |  |  |  |
| dizziness |  |  |  |
| difficulty breathing |  |  |  |