Subject Initials/Number:	Date:	Visit:	Protocol :
Check Appropriately: □ rTMS □ Single pulse TMS □ Paired pulse TMS			

Do you have any of the following symptoms?							
Symptoms	Yes/No If "yes" to any symptoms, fill out severity and relationship		Severity 1= Absent 4= Severe 2 = Mild 3= Moderate		Relationship 1 = None 4 = Probable 2 = Remote 5 = Definite 3 = Possible		Comments
	Pre	Post	Pre	Post	Pre	Post	
Headache							
Neck Pain							
Scalp Pain/Irritation							
Only ask the following Questions Post-TMS							
Are you having any trouble hearing compared to when you arrived?							
Are you having any trouble with your thinking compared to when you arrived?							
Are you having any trouble concentrating compared to when you arrived?							
Do you have any change in your mood (positive or negative)?							
Is there anything else that you would like to tell me?							
Did the subject have a syncopal event, a seizure or any other adverse effect during or post-TMS ?							