Subject ID: PI:

Participant Report of Symptoms

Type of Non-Invasive Brain Stimulation: TMS____tFUS_____Other (Describe):______________________

Visit Date:		**POST** Time: Investigator:	
How are you feeling overall right now?	Participant		
"Right now, do you feel you have or are……?"		**Value** 1 absent 2 mild 3 moderate 4 severe	**Relation** 1 unrelated 2 unlikely 3 possible 4 probable 5 definite
Headache			
Unusual feelings on the skin of your head			
Neck pain			
Tingling			
Itchiness			
Sleepiness			
Difficulty paying attention			
Unusual /feelings, attitude, emotions			
Tooth pain			
Change in hearing			
Nausea/Sick to Stomach			
Unusual twitches or movements in muscles			
Dizziness			
Anxious/Worried/Nervous			
Forgetful			
Difficulty with your balance			
Change in movement in your stronger hand			
Abnormal sleep last night			
Seizure within the last 24 hours			
Other:			