Questionnaire of sensations related to transcranial electrical stimulation (TES)

(To be filled in by the participants and by the investigator)

Investigator:

Participant name/code:_____ **Date**:___/____/____|

Experiment/Treatment: _____

No stimulations experienced before □ **Experienced** □ # of **stimulations sessions before: …….**

Type of electrical stimulation used here_____ **Intensity** ____mA (if known)

Electrodes dimension: anode (if known) ___*___ cathode (if known) ___*___ (shape _____)

other_____

Participant:

Did you experience any discomfort during the electrical stimulation? Please indicate the degree of intensity of your discomfort according to the following scale:

- **None =** **I did not feel the sensation addressed**
- **Mild =** **I mildly felt the sensation addressed**
- **Moderate =** **I felt the sensation addressed**
- **Strong =** **I felt the sensation addressed to a considerable degree**

In the first stimulation block I felt (to be filled in by subject, if it is possible please separate the sensations with regard to the electrode positions):				
	None	*Mild*	*Moderate*	*Strong*
Itching	□	□	□	□
Pain	□	□	□	□
Burning	□	□	□	□
Warmth/Heat	□	□	□	□
Metallic/Iron taste	□	□	□	□
Fatigue/Decreased alertness	□	□	□	□
Other	□	□	□	□

4 hrs

In case of perceived sensation, when did it begin*? (this part can be multiplied and completed for each sensation, e.g. one for pain, one for itching etc and could/should be modified according to the type of experiments)*

□ At the beginning; □ At approximately in the middle; □ Towards the end of the stimulation

Duration (multiple options allowed)

□ Only initially □ It stopped in the middle of the block □ It stopped at the end of the block

How much did these sensations affect your general state?

□ Not at all □ Slightly □ Considerably □ Much □ Very much

Location of sensations:

□ Diffuse □ localized □ close to the electrode, (which one?)_____; □ Other_____

If you would like to provide more details, please briefly describe the experimented sensations in relation to the "Other" or "Fatigue" or ….. response:

In the second stimulation block

(if there is more than one condition, repeat the list above here based on the block numbers)

To be administered at the end of the entire experiment

Do you believe that you received a real or placebo stimulation?

In the first stimulation block/day/week: □ real □ placebo □ I don't know

In the second stimulation block/day/week: □ real □ placebo □ I don't know

Investigator*:*

Please report any adverse event/problem (typically skin irritation and redness – separately for the electrodes -, headache, scalp pain, dizziness, or others, please specify) that occurred and rate the event/problem on a scale from 0 to 3 as previously described.

_____
_____
_____
_____

Additional comments:

_____
_____
_____

A structured questionnaire on intensity and frequency of AEs increases safety, when transcranial electrical stimulation is used. It is a recommended procedure for publication of TES experiments/trials.