Transcranial ultrasound stimulation (TUS) is a non-invasive brain stimulation method that uses low-intensity sound energy to change brain activity. Some implants, medications or neurological conditions may pose a safety risk with TUS. Please answer the following questions carefully. The researcher will go through the form with you, so you will have the opportunity to ask about anything you are unsure of.

First Name:	Last Name:
1st Line of Address:	Date of Birth:

Have you had non-invasive brain stimulation before? (e.g. TMS, tDCS, TUS)	Yes / No
Have you ever had brain surgery or serious head trauma?	Yes / No
Do you have epilepsy or a history of seizures? Do any close relatives (i.e. parents, siblings, children) have epilepsy or a history of seizures?	Yes / No Yes / No
Do you have a predisposition for fainting spells (syncope)?	Yes / No
Do you have a current diagnosis of any neurological or psychiatric conditions? (including depression, generalized anxiety, panic attacks, AD(H)D, stroke, brain tumours, migraines, extreme mood fluctuations, etc.)?	Yes / No
Are you currently taking any prescription or non-prescription medication (excluding anti-conception)? If yes, please list:	Yes / No
Have you consumed more than four alcoholic units within the past 24 hours, or any recreational drugs within the past 48 hours?	Yes / No

If you **have not filled in an MRI safety questionnaire today**, please answer the following questions:

Is there any possibility that you may be pregnant?	Yes / No
Do you have a cardiac pacemaker or intra-cardiac lines?	Yes / No
Do you have an implanted neurostimulator?	Yes / No
Do you have an implanted medication infusion device?	Yes / No
Do you have a cochlear implant?	Yes / No
Do you have anything else implanted in you that you can't completely remove? (e.g. implanted metal devices, large ferromagnetic fragments in the head or upper body (excluding dental wire), jewellery or piercings that cannot be removed, etc.)	Yes / No
Do you have any metal in the brain, skull or elsewhere in your body? (e.g. shrapnel, fragments, clips, etc.)	Yes / No
Do you use a medical plaster that cannot or may not be removed? (e.g. nicotine plaster)	Yes / No

I CONFIRM THAT I HAVE READ AND COMPLETED THIS FORM AND THAT IT IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND I AM WILLING TO UNDERGO THE TUS PROCEDURE. **Is there anything else you think we should know?** Please write below:

Volunteer signature:	Date:
Signature of researcher undertaking safety check:	