tDCS Adverse Event Reporting Form

Subject ID: ________________________________ Date: ________

Notes on tDCS protocol:

1-Absent	1-None
2-Mild	2-Remote
3-Moderate	3-Possible
4- Severe	4-Probable
5-Definite	

Did you experience any of the following symptoms/side effects?	**Severity**	**Relationship**	**Notes**
Headache			
Neck Pain			
Scalp Pain			
Tingling			
Burning sensation			
Skin redness			
Sleepiness			
Trouble concentrating			
Acute Mood Changes (Indicate Direction)			
Other (specify)			