

Post-stimulation Questionnaire

Which stimulation intensity is it? 0 1 2 3 (mA)

During tDCS:

- | | | | | | | |
|--------------------------------|---|---|---|---|---|---|
| • Visual sensation (start/end) | 0 | 1 | 2 | 3 | 4 | 5 |
| • Itching sensation | 0 | 1 | 2 | 3 | 4 | 5 |
| • Tingling | 0 | 1 | 2 | 3 | 4 | 5 |
| • Burning sensation | 0 | 1 | 2 | 3 | 4 | 5 |
| • Pain | 0 | 1 | 2 | 3 | 4 | 5 |
| • Others: | | | | | | |
| _____ | 0 | 1 | 2 | 3 | 4 | 5 |
| _____ | 0 | 1 | 2 | 3 | 4 | 5 |
| _____ | 0 | 1 | 2 | 3 | 4 | 5 |

After tDCS

- | | | | | | | |
|---------------------------------|---|---|---|---|---|---|
| • Skin redness | 0 | 1 | 2 | 3 | 4 | 5 |
| • Headache | 0 | 1 | 2 | 3 | 4 | 5 |
| • Fatigue | 0 | 1 | 2 | 3 | 4 | 5 |
| • Difficulties in concentration | 0 | 1 | 2 | 3 | 4 | 5 |
| • Nervousness | 0 | 1 | 2 | 3 | 4 | 5 |
| • Sleeping problems | 0 | 1 | 2 | 3 | 4 | 5 |
| • Others: | | | | | | |
| _____ | 0 | 1 | 2 | 3 | 4 | 5 |
| _____ | 0 | 1 | 2 | 3 | 4 | 5 |
| _____ | 0 | 1 | 2 | 3 | 4 | 5 |