**Consent Form: Participant**

Project title: **The effects of vestibular inputs on somatosensory perception using nGVS in healthy adults.**

Project Supervisor: Professor Denise Taylor

Researcher: Preet Kamal Kaur

* I have read and understood the information provided about this research project in the Information Sheet dated …………………………..2022.
* I have had an opportunity to ask questions and to have them answered.
* I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
* I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
* I do not have a pacemaker or any metal implants in my head or neck region.
* I am right-handed.
* I have no history of falls more than twice in past 6 months YesNo
* I am not suffering from any medical condition.
* I am not suffering with any cognitive impairment YesNo
* I agree researcher can touch my head and neck (please tick one):   YesNo
* I agree to take part in this research.
* I agree to data being used for future research.
* I wish to receive a summary of the research findings (please tick one): YesNo
* I wish to receive my individual results (please tick one): YesNo
* I agree the data related to me from this research can be used for future studies (please tick one): YesNo
* I agree to being contacted about future research opportunities at AUT:  YesNo

Participant’s signature:.....................................................…………………………………………………………

Participant’s name:.....................................................…………………………………………………………

Participants Contact Details

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Date:

***Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number***

Note: The Participant should retain a copy of this form.

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**Edinburgh Handedness Inventory**

Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Given Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate your preferences in the use of hands in the following activities by *putting + in the appropriate column*. Where the preference is so strong that you would never try to use the other hand unless absolutely forces to, *put ++*. If any case you are really indifferent put + in both columns.

Some of the activities require both hands. In these cases the part of the task, or object, for which hand preference is wanted is indicated in brackets.

Please try to answer all rows (From which hand you do the following activities), and only leave a blank if you have no experience at all of the object or task.

|  |  |  |
| --- | --- | --- |
|  | Left | Right |
| 1. Writing |  |  |
| 1. Drawing |  |  |
| 1. Throwing |  |  |
| 1. Scissors |  |  |
| 1. Toothbrush |  |  |
| 1. Knife (without fork) |  |  |
| 1. Spoon |  |  |
| 1. Broom (upper hand) |  |  |
| 1. Striking Match (match) |  |  |
| 1. Opening box (lid) |  |  |
|  |  |  |
| 1. Which foot you prefer to kick with |  |  |
| 1. Which eye do you use when using only one |  |  |

|  |
| --- |
| L.Q Leave the space blank DECLE |

### Data values

**The cell values in the data should be coded from -2 through 0 to 2, and there should be a single value per question.**

**-2: Left hand dominance 1: Right hand preference  
-1 : Left hand preference 2 : Right hand dominance  
0 : No preference**

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**HEALTH SCREENING FORM**

**Personal details: DOS:**

Participant name:

Gender:

Ethnicity:

DOB:

Handedness: …………………………………..

Participant phone number:

Participant email:

### Medical History:

|  |  |
| --- | --- |
|  | **Tick appropriate box** |
| Neurological Impairment |  |
| Medical condition that can influence your balance such as inner ear problem, diabetes, epilepsy, recurring headaches |  |
| Active Benign Paroxysmal Positional Vertigo |  |
| Speech Dysfunction or cognitive impairment |  |
| History of more than two falls in last 6 months |  |

Other:

|  |  |
| --- | --- |
|  | **Tick appropriate box** |
| Left Handedness |  |
| Cardiac pacemaker |  |
| Any metal implants in head or neck |  |
| Any metal implants in right foot |  |
| Difficulty in standing |  |
| Standing with assistance |  |
| Skin conditions (Allergies for sticking plasters) |  |

**Any tick in the orange shaded box results in NOT ELIGIBLE**

**Eligible: Not Eligible**

Screened by: Date: