Supplementary Material 2

SATISFACTION AND ADVERSE EFFECTS QUESTIONNAIRE
Noninvasive Brain Stimulation Combined with Restriction-Induced Movement Therapy for Motor and Functional Recovery of Stroke Patients: Multicenter Randomized Clinical Trial

Name:

Age: Sex:

Evolution time:

Laterality:

Affected member: Occupation:

Question	Very agree	Agree	Neither agree, nor disagree	Disagree	Very disagree
Satisfaction of intervention					
1- Feel that you were properly informed/or about the treatment.					
2- The attention of professionals is friendly and cordial.					
3- Communication between you and the OT is clear and timely.					
4- You are satisfied with the quality of the OT care.					
5- You feel comfortable in the environment you are in during the procedures.					
6- You feel secure and confident with the procedure.					
7- Do you feel that there was improvement in the mobility of your affected arm after the intervention received?					
8- Do you feel that there were improvements in the performance of your affected arm in everyday activities?					

Aspects of the intervention					
1- You are comfortable with the activities that take place during the session.					
2- Considers that the duration of the sittings					
3- You feel tired after the sessions.					
4- Feel that 2 daily sessions are suitable to improve the movement of your affected arm					
5- You believe that the tasks or activities of the session are beneficial for your recovery					
6- He likes the activities that take place during the session.					
7. Do you think the use of the glove helped you to incorporate your affected arm more into the activities?					
Relationship between intervention and everyday life					
1- Have you seen advances in personal cleaning activities, such as combing or brushing your teeth?					
2- Has seen advances in eating					
3- Has seen progress in clothing activities in senior member					
4- Has seen advances in clothing activities on lower limb.					
5- Has seen progress in selected activities upon completion of rehabilitation					
6- It is pleased with the progress it has made to date.					

You think he got brain stimulation?

☐Yes ☐ No ☐ Don´t know. f the answer is Yes or You Don’t Know, answer the next question.

Question	No discomfort	Mild discomfort	Moderate discomfort	High discomfort
Electrical StimulationTranscranial				
Did you experience any discomfort during electrical stimulation?				

If the answer is yes, answer: What did you feel? Select all the ones the patient refers to.

	Select from	
Itching	☐	
Pain	☐	
Burning	☐	
Warmth	☐	
Fatigue/tiredness	☐	
Other	☐	