Form A – Participant Consent and Eligibility Form

Study Title: Evaluating Integral Eye Movement Therapy (IEMT) for the Reduction of Fear and Phobia Symptoms: A Focus on Arachnophobia (Phobia of Spiders)

Research Lead: The Association for IEMT Practitioners

Informed Consent

Please read each statement and initial each box to confirm your understanding:

- **[ ] I understand the purpose of this study and agree to participate in three free IEMT sessions aimed at reducing spider phobia.**
- **[ ] I understand that I can withdraw at any time without explanation and without any consequences.**
- **[ ] I understand that IEMT involves eye movement techniques and is not a substitute for psychiatric or medical care.**
- **[ ] I agree to the use of my anonymized data for research, analysis, and academic publication.**

Participant Name: _____

Signature: _____ **Date:** _____

Clear Form

Contraindications Checklist

Please read each statement and tick either "Yes, this applies to me" or "No, this does not apply to me".

1. I have epilepsy that is not medically controlled, or I have a history of dizziness or seizures triggered by eye movement.

   [■] Yes, this applies to me [ ] No, this does not apply to me

2. I have medically controlled epilepsy and have consulted my neurological care team.

   [ ] Yes, this applies to me [ ] No, this does not apply to me

3. I have a diagnosed neurological disorder such as Parkinson's, Multiple Sclerosis, Motor Neurone Disease or Alzheimer's.

   [ ] Yes, this applies to me [ ] No, this does not apply to me

4. I have had a head injury or brain surgery in the last 6 months.

   [ ] Yes, this applies to me [ ] No, this does not apply to me

5. I have experienced severe trauma within the last 6 months.

   [ ] Yes, this applies to me [ ] No, this does not apply to me

6. I am currently pregnant and experiencing severe nausea (Hyperemesis gravidarum).

   [ ] Yes, this applies to me [ ] No, this does not apply to me

7. I have been diagnosed with a psychiatric condition such as drug induced psychosis, schizophrenia, schizoaffective disorder, post-partum psychosis, depression with psychotic symptoms or bipolar disorder.

   [ ] Yes, this applies to me [ ] No, this does not apply to me

8. I am currently experiencing vertigo, Meniere's disease, or labyrinthitis.

   [ ] Yes, this applies to me [ ] No, this does not apply to me

9. I am under the influence of alcohol or recreational drugs.

   [ ] Yes, this applies to me [ ] No, this does not apply to me

10. I am currently in therapy using another therapeutic methodology.
    [ ] Yes, this applies to me [ ] No, this does not apply to me

11. I am due to give testimony in court, and understand IEMT may affect memory recall and my testimony may therefore be discounted.
    [ ] Yes, this applies to me [ ] No, this does not apply to me

12. I am seeking IEMT as a substitute for conventional psychiatric or medical treatment.
    [ ] Yes, this applies to me [ ] No, this does not apply to me

Note: If any box is marked "Yes, this applies to me," the participant **should not proceed** with IEMT as part of this study.

Practitioner Use Only:

Participant is eligible to proceed: [ ] YES [ ] NO

Practitioner Name: _____

Date Reviewed: _____

Clear Form