First Seizure Description Sheet

Directions

Before your appointment, describe the different types of seizure-like events your child has. If you were not the witness, talk with the person who saw the events first-hand to fill out the details below. Use whatever language your family uses to describe them, such as "the checking out type" or "the shaking all over type." If you are not sure, complete it as best as you can.

We will review this information with you at your child's appointment. If possible, send it in before your appointment and take videos of the events.

Child's Name: ______________________________

Date of birth: ______________________________

Date of my child's very first seizure-like event: ____________

Event type 1: ______________________ (description)

Triggers

Check all that apply:

- ❑ Lights
- ❑ Over-tired (sleep deprivation)
- ❑ Fever
- ❑ Medicine
- ❑ Head injury
- ❑ Other: ______________________

Characteristics during the event

Check all that apply:

- ❑ Eye fluttering
- ❑ Drooling
- ❑ Twitching or jerking
- ❑ Lip smacking or chewing
- ❑ Tongue biting
- ❑ Peeing or soiling pants (incontinence)
- ❑ Fall or drop attack
- ❑ Stops activity
- ❑ Repeated head, arm or leg spasm
- ❑ Spells suppressible
- ❑ Staring or other change in consciousness
- ❑ Other: ______________________

Symptoms after the event

Check all that apply:

- ❑ Headache
- ❑ Fatigue
- ❑ Very sleepy
- ❑ Limb weakness
- ❑ Difficulty with speech
- ❑ No symptoms after the event
- ❑ Other: ______________________________

To Learn More

- Neurology
  (07) 3163-3636
- Ask your child's healthcare provider
- www.brisbanechildneurology.com.au

Frequency of the events

Check all that apply:

- ❑ Daily
- ❑ Weekly
- ❑ Monthly
- ❑ Happen at night
- ❑ Happen during the day
- ❑ Last for seconds (less than 1 minute)
- ❑ Last for minutes (less than 1 hour)
- ❑ Last for hours

Event type 2: ______________________________ (description)

Triggers

Check all that apply:

- ❑ Lights
- ❑ Over-tired (sleep deprivation)
- ❑ Fever
- ❑ Medicine
- ❑ Head injury
- ❑ Other: ______________________________

Characteristics during the event

Check all that apply:

- ❑ Eye fluttering
- ❑ Drooling
- ❑ Twitching or jerking
- ❑ Lip smacking or chewing
- ❑ Tongue biting
- ❑ Peeing or soiling pants (incontinence)
- ❑ Fall or drop attack
- ❑ Stops activity
- ❑ Repeated head, arm or leg spasm
- ❑ Spells suppressible
- ❑ Staring or other change in consciousness
- ❑ Other: ______________________________

Symptoms after the event

Check all that apply:

- ❑ Headache
- ❑ Fatigue
- ❑ Very sleepy
- ❑ Other: ______________________________
- ❑ Limb weakness
- ❑ Difficulty with speech
- ❑ No symptoms after the event

Frequency of the events

Check all that apply:

- ❑ Daily
- ❑ Weekly
- ❑ Monthly
- ❑ Happen at night
- ❑ Happen during the day
- ❑ Last for seconds (less than 1 minute)
- ❑ Last for minutes (less than 1 hour)
- ❑ Last for hours

Event type 3: ______________________________ (description)

Triggers

Check all that apply:

- ❑ Lights
- ❑ Over-tired (sleep deprivation)
- ❑ Fever
- ❑ Medicine
- ❑ Head injury
- ❑ Other: ______________________________

Characteristics during the event

Check all that apply:

- ❑ Eye fluttering
- ❑ Drooling
- ❑ Twitching or jerking
- ❑ Lip smacking or chewing
- ❑ Tongue biting
- ❑ Peeing or soiling pants (incontinence)
- ❑ Fall or drop attack
- ❑ Stops activity
- ❑ Repeated head, arm or leg spasm
- ❑ Spells suppressible
- ❑ Staring or other change in consciousness
- ❑ Other: ______________________________

Symptoms after the event

Check all that apply:

- ❑ Headache
- ❑ Fatigue
- ❑ Very sleepy
- ❑ Limb weakness
- ❑ Difficulty with speech
- ❑ No symptoms after the event
- ❑ Other: ______________________________

Frequency of the events

Check all that apply:

- ❑ Daily
- ❑ Weekly
- ❑ Monthly
- ❑ Happen at night
- ❑ Happen during the day
- ❑ Last for seconds (less than 1 minute)
- ❑ Last for minutes (less than 1 hour)
- ❑ Last for hours

Please send this completed form to:

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