

MY SEIZURE EVENT DIARY

NAME: _____

 Instructions: • Use 1-column for each event.
 • Check off all behaviors that apply.

During Seizures		Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time
Awareness	Fully Aware							
	Confused							
	Responds to Voice							
	Not Responsive							
Facial Expressions	Staring							
	Twitching							
	Eyes Rolling							
	Eyes Blinking							
Head Movements	Sudden Head Drop							
	Turns to 1-Side							
	Turns Side to Side							
Body Stiffens	Whole Body							
	Legs							
	Arms							
Jerking Movement	Whole Body							
	Legs							
	Arms							
Automatic Movement	Hands Clapping, Rubbing							
	Lip Smacking, Chewing							
	Walking, Wandering							
	Running							
Speech	Able to Talk Normally							
	Unable to Talk							
	Incoherent/Nonsense Words							
	Mixing up Words							
Fall	Fall - Yes/No							
After Seizure	Fully Aware							
	Responds Normally							
	Confused							
	Tired							
	Asleep							
	Agitated, Irritable							
	Incontinent - Yes/No							
	Injury - Type/No							
Time	Length of Seizure							
	Length of Recovery Period							
Interventions	Rescue Medicine Given							
	VNS Magnet							
Triggers - List any possible triggers								
Name of Observer								