SEIZURE OBSERVATION RECORD

The *Seizure Observation Record* provides a guided, detailed format to keep track of a person's seizures.
You can use this form to help you track your child's seizures or use the *Seizure Log* to keep an ongoing record.

Name:	**SEIZURE # 1**		**SEIZURE # 2**	
Date and Time				
PRE-SEIZURE CONDITIONS				
List and describe behaviors, triggers, activities, etc.				
Awake when seizure started? (yes, no, altered consciousness)				
Injuries sustained during seizure (briefly describe)				
SENSATIONS EXPERIENCED BY PERSON BEFORE/DURING SEIZURE	**Circle Yes or No**		**Circle Yes or No**	
Feeling that something has already happened (déjà vu)	Yes	No	Yes	No
“Funny” taste in the mouth	Yes	No	Yes	No
“Funny” feeling in the stomach	Yes	No	Yes	No
Changes in vision (blurriness, etc.)	Yes	No	Yes	No
Changes in hearing	Yes	No	Yes	No
Strange or surprising smells	Yes	No	Yes	No
MUSCLE TONE/BODY MOVEMENT	**Circle Yes or No**		**Circle Yes or No**	
Rigid/Clenching	Yes	No	Yes	No
Limp	Yes	No	Yes	No
Fell down	Yes	No	Yes	No
Rocking	Yes	No	Yes	No
Wandering Around	Yes	No	Yes	No
Whole body jerking	Yes	No	Yes	No
EXTREMITY MOVEMENTS	**Circle Yes or No**		**Circle Yes or No**	
Right arm jerking	Yes	No	Yes	No
Left arm jerking	Yes	No	Yes	No
Right leg jerking	Yes	No	Yes	No
Left leg jerking	Yes	No	Yes	No
Random arm/leg movement	Yes	No	Yes	No
COLOR	**Circle Yes or No**		**Circle Yes or No**	
Bluish	Yes	No	Yes	No
Pale	Yes	No	Yes	No
Flushed	Yes	No	Yes	No

SEIZURE OBSERVATION RECORD CONTINUED

	SEIZURE # 1		SEIZURE # 2	
EYES	**Circle Yes or No**		**Circle Yes or No**	
Pupil Dilated	Yes	No	Yes	No
Turned to one side (right or left)	Yes	No	Yes	No
Rolled up/Not visible	Yes	No	Yes	No
Staring or Blinking	Yes	No	Yes	No
Closed	Yes	No	Yes	No
MOUTH	**Circle Yes or No**		**Circle Yes or No**	
Salivating	Yes	No	Yes	No
Chewing	Yes	No	Yes	No
Lip Smacking	Yes	No	Yes	No
OTHER SYMPTOMS (PLEASE DESCRIBE)	**Circle Yes or No**		**Circle Yes or No**	
Verbal Sounds (gagging, talking, throat clearing, etc.)	Yes	No	Yes	No
Breathing (normal, heavy, stopped, noisy, etc.)	Yes	No	Yes	No
Incontinence (urine or feces)	Yes	No	Yes	No
Other				
POST-SEIZURE OBSERVATION	**Circle Yes or No**		**Circle Yes or No**	
Confused	Yes	No	Yes	No
Sleepy/Tired	Yes	No	Yes	No
Headache	Yes	No	Yes	No
Slurred Speech	Yes	No	Yes	No
Other				
OTHER DETAILS	**SEIZURE # 1**		**SEIZURE # 2**	
Seizure Length				
How long to full awareness?				
Parent/Guardian Notified? (Time of Call)				
EMS Called? (Time of Call and Arrival Time)				
Observer's Name				
Additional Comments				