

SEIZURE EVENT RECORD

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



Name: _____

During Seizure	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time
Awareness							
Fully Aware							
Confused							
Responds to Voice							
Responds to Light Touch							
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 Movements							
Whole Body							
Legs							
Arms							
Automatic Movements							
Hands clapping, rubbing							
Lip Smacking, Chewing							
Walking, Wandering							
Running							
Speech							
Able to Talk Normally							
Unable to Talk							
Incoherent/Nonsense Words							
Mixing Up Words							
Falls							
Yes/No							
Injury							
Yes/No							
Type of Injury							
Incontinent							
Yes/No							
After Seizure							
Fully Aware							
Responds Normally							
Confused							
Tired							
Asleep							
Agitated, Irritable							
Length of Seizure							
Before Return to Baseline							
Interventions							
VNS Magnet							
Medicine Given							
Triggers							
Name of Observer							