[Standard Header]

Claimant Name: [Clmt_Full_Name]

PLEASE COMPLETE AND RETURN BY {clmt_form_return_date}

SEIZURE QUESTIONNAIRE

If you need more space, please attach additional page(s).

1) Do you have seizures? ☐ Yes ☐ No

If yes:

a) What is the date of your first seizure? ____

b) What is the date of your last seizure? ____

c) What type of seizure(s) do you typically experience? (for example, tonic-clonic, focal, myoclonic, etc.)

____

d) How long does the seizure(s) typically last?
____

e) How often do your seizures occur?
____

f) List the approximate date(s) of your seizure(s) in the last 12 months.

____

____

g) Describe what happens before you experience a seizure:

____

____

____

h) Describe what happens to you while you are having a seizure:

____

____

____

i) Describe what happens to you immediately after having a seizure and how long before you can resume normal activity:

____

____

____

2) Describe activity(ies) that may trigger your seizure(s). For example, heights, exposure to flashing lights or patterns, drinking alcoholic beverages, stress, lack of sleep, etc.

____

____

____

3) Does your seizure disorder or the medication you take for seizures cause you any physical problems? For example, standing up, walking, seeing, breathing, or maintaining balance, etc.

☐ Yes ☐ No

If yes, explain: ____

____

4) Does your seizure disorder or the medication you take for seizures cause you any problems with understanding, remembering, or applying information? ☐ Yes ☐ No

If yes, explain: ____

____

5) Does your seizure disorder or the medication you take for seizures cause you any problems with interacting with others? ☐ Yes ☐ No

If yes, explain: ____

____

6) Does your seizure disorder or the medication you take for seizures cause you any problems with concentrating, persisting, or maintaining pace? ☐ Yes ☐ No

NAME OF HEALTH CARE PROFESSIONAL	NAME OF CONDITION THEY TREAT	ADDRESS AND PHONE NUMBER	DATE OF LAST VISIT AND NEXT SCHEDULED VISIT (IF ANY)

If yes, explain: ____

____

7) Does your seizure disorder or the medication you take for seizures cause you any problems with adapting or managing yourself? ☐ Yes ☐ No

If yes, explain: ____

____

8) If you have seen any health care professionals for your seizures and/or any of the problems discussed in questions 3-7 above, since you filed your claim, complete the chart below.

9) If anyone (example: doctor, family member, non family member) has witnessed your seizure(s), please complete the chart below.

WITNESS NAME	ADDRESS	PHONE NUMBER

10) Have you visited an emergency room for seizures? If so, when and where?

____

____

11) List current seizure medication(s) in the table below.

MEDICATION, DOSAGE, AND FREQUENCY	DATE STARTED	IF PRESCRIBED, NAME OF HEALTH CARE PROFESSIONAL	SIDE EFFECT(S)

12) If you listed names and contact information in response to questions 9 through 11 above, do we have your permission to contact them? ☐ Yes ☐ No

____ ____________ ___________________
Name of person completing this form (Please print) Date Phone

Address	City	State	Zip Code