Medical Seizure Information Form

(This form is to be used for additional information for applicants applying for a Seizure Response Service Dog)

Applicant Name:_____

Neurologist Name:_____

Neurologist Address:_____

Type of Seizures you experience: *(check all that apply)*

[ ] Simple partial — How long does the seizure activity last? _____

[ ] complex partial (temporal lobe) — How long does the seizure activity last? _____

[ ] Tonic –clonic (grand mal) — How long does the seizure activity last? _____

[ ] Absence (petit mal) — How long does the seizure activity last? _____

[ ] Myoclonic — How long does the seizure activity last? _____

[ ] West Syndrome — How long does the seizure activity last? _____

[ ] Lennox –Gastaut Syndrome — How long does the seizure activity last? _____

[ ] Status Epilepticus — How long does the seizure activity last? _____

[ ] Other – explain_____

During any of your seizures, do you experience walking without cognitive awareness, combative behavior, running, screaming or yelling, facial movements, post ictal fugue (length), inability to breathe or other effects? _____ Yes _____No

If yes, please explain: _____

_____

Are you left handed? _____ Yes _____No

Are you right handed? _____ Yes _____No

How often do you experience seizure episodes:

[ ] More than once a day – How many?_____

[ ] Once a day

[ ] 3 to 4 times a week

[ ] once a week

[ ] 3 to 4 times a month

[ ] Once a month or less - How often? _____

[ ] When was your last seizure? ____ / ____ / ____

Do you get a warning before your seizures? _____ Yes _____No

Have you ever seen a video of your seizure activity? _____ Yes _____No

List all physical side effects caused by seizure activity: _____

_____

_____

_____

Describe what your seizures "look" like (someone else in your family may need to provide the description):

_____

_____

_____

_____

Do you experience cognitive difficulties before, during, or after seizure activity?

[ ] yes [ ] no If yes please explain: _____

_____

_____

_____

Are you weak on one side of your body after a seizure? [ ] yes [ ] no

Are your seizures controlled by medication? [ ] yes [ ] no

Are you able to speak after a seizure? [ ] yes [ ] no

Do seizures cause you to fall? [ ] yes [ ] no

If yes, what direction do you fall (please circle): To the left To the right Forward Backward

Have you ever had an EEG? [ ] yes [ ] no

If yes, did the EEG show activity <u>before</u> the breakthrough seizure? (you may need to ask your physician)? [ ] yes [ ] no

If yes, was the EEG videotaped? [ ] yes [ ] no If yes, please provide a copy of the video.

Do you have a Vagus Nerve Stimulator? [ ] yes [ ] no If yes, when was it implanted: _____

Do you use any monitoring devices? [ ] yes [ ] no If yes, please list: _____

_____

List medications you are currently taking:

_____ _____

_____ _____

Do you experience any cognitive side effects caused by any medications you are taking? [ ] yes [ ] no
If yes, please explain: _____

Are there any modifications needed to accommodate your disability during our training camp? [ ] yes [ ] no

If yes please explain: _____

_____

_____

Tell us how seizures affect your daily life:

_____

_____

_____

How would you want a service dog to assist you?

_____

_____

_____