**Monthly Seizure Diary** **Month/Year** _____ **Name**_____

We have requested that you keep a seizure diary and submit them on a quarterly basis. The seizure diary is intended to give Social Security an idea of what it's like for you to live with your challenges. Please record each day you experience a seizure of any type and fill out the corresponding information. If there is any additional information you need to add, do so at the end of the page and include the date of each entry. We need this information every 3 months so we can keep Social Security informed of your condition.

Please send it to us at the end of March, June, September, and December by: email **records@mkhansenlaw.com**, fax **(402) 477-0231**, or mail **1101 Cornhusker Hwy., Suite 201 Lincoln, NE 68521**

| Date | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Did you have a seizure today?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Intensity of Seizure PARTIAL-Affected only one side of the body; PETIT MAL-Never lost consciousness but in an altered state of consciousness; GRAND MAL-Lost consciousness** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Partial | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Petit | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Grand | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Duration of this seizure?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <30seconds | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30s-2min | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| >2min | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Were there any warning signs you were able to recognize before your seizure?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Stomach upset | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Strange smells/tastes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sudden Fear/Euphoria | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Auras | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **What occurred during your seizure** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tingling | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Convulsion/Shaking | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Visual Loss | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Drooling | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Incontinence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Breathing Difficulty | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Blackout | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nausea | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Abnormal behavior | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Numbness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mood Changes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Symptoms after your seizure was over** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Confusion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Memory loss | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Writing Difficulty | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fear | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Depression | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Shame/Guilt | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Exhaustion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Headache | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Weakness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nausea | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **How long did these post-seizure symptoms last?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Less than 5min | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5-30min | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Greater than 30min | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Did you feel the need to nap after your seizure?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Did you have any resulting injury (ex. Bruising, head trauma, fractures etc.) from your seizure? If yes, please write details in the additional information section** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Did you require assistance from another individual or emergency service with this seizure? If yes, please write details in the additional information section** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Were there any contributing factors or cause for this seizure? If yes, lease write details in the additional information section** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Stress | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No medication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other Health Issue | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

If there is any other information you would like to include please enter that below. For instance, if there was a symptom not on the list that you experienced, describe it and include the date it occurred. If you were taken to the hospital or doctor please include date, provider and place you were seen, along with any other details. Detailed explanations and additional information will be helpful to the development of your case. We appreciate your help in developing your case.

Additional Information: