

SEIZURE DESCRIPTION FORM (Witness)

PATIENT: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

Please answer the following questions based on your actual observations.

1. Dates of seizures witnessed:

2. Does the claimant have the seizures during the day, during the night, or both?

3. How often does the claimant have seizures?

4. How many seizures have you witnessed?

5. When was the last time the claimant had a seizure of which you are aware?

6. Please describe a typical seizure by answering the following questions:
 - a. Does the claimant lose consciousness? Yes _____ No _____
If yes, for how long? _____
 - b. Does the claimant bite his/her tongue? Yes _____ No _____
 - c. Does he/she lose bladder or bowel control? Yes _____ No _____
 - d. Has he/she been injured during a seizure? Yes _____ No _____
 - e. Please try to describe his/her behavior immediately following a seizure:

7. Please give a phone number where you can be reached:

8. What is your relationship to the claimant?

Signature: _____
Name: (Print) _____
Address: _____
Telephone: _____

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