**Patient Survey**

Directions: Survey will be administered by study staff and questions will be read to the patient in the patient's preferred language.

**Name of Patient:** ­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Evaluation:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ (day/month/year) **Name of Evaluator:** ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Village:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **District:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tel/mobile:** ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age (years):** \_\_\_\_\_\_\_\_\_\_ **Date of birth:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ (day/month/year)

**Gender (circle one):**  Male Female

**Highest education level completed (circle one):**

no school primary school secondary school high school university

**Religion of child/family (circle all that apply):**

Muslim Christian Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How old were you when you had your first seizure (years):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been diagnosed with epilepsy?** Yes No

* **If yes, how old were you when diagnosed (years):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **If yes, who diagnosed you? (circle all that apply)**

medical doctor (western/modern) traditional healer other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you characterize your seizures? (Check all that apply)**

**□** loss of consciousness

**□** falling to ground with stiffening and shaking of body

**□** falling to ground, no shaking

**□** uncontrollable shaking of one part of the body

**□** staring spells

**□** unusual behavior or acting strangely

**□** communicating with spirits

**□** unusual sensory events (vision hearing touch smell taste)

**□** tongue biting

□ urinary incontinence

□ salivation

□ grunts/shouting/noises of some form

**□** other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many seizures have you had total?:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How many seizures have you had in the past month?:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When was your last seizure? (check one)**

**□** within the last week **□** within the last month

**□** within the last 3 months □ within the last 6 months

□ within the last 9 months □ within the last year

□ over 1 year ago

**Do any of the following trigger your seizures? (check all that apply)**

**□** infections/fever **□** lack of sleep **□** flashing lights **□** stress **□** alcohol

**□** forgetting to take medications **□** other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizure Treatment

**Have you ever taken medication for epilepsy (AEDs)?** Yes No

**Are you currently taking medications for epilepsy (AEDs)?** Yes No

If not, why did you stop taking the medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **When did you first start treatment for seizures?** (Age, in years): \_\_\_\_\_\_\_\_\_
* **Do you take your medications regularly?** Yes No

If no, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Which medications or treatments? (check all that apply and complete questions)**

**□** Phenobarbital Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Currently taking **□** Not anymore

**□** Phenytoin Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Currently taking **□** Not anymore

**□** Carbamazepine Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Currently taking **□** Not anymore

**□** Sodium Valproate Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Currently taking **□** Not anymore

**□** Levetiracetam Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Currently taking **□** Not anymore

**□** Clonazepam Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Currently taking **□** Not anymore

**□** Clobazam Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Currently taking **□** Not anymore

**□** Diazepam Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Currently taking **□** Not anymore

**□** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Current **□** Not anymore

* **List any side effects from medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever used non-AED treatments for seizures?**

**□** Special diet Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Currently taking **□** Not anymore

**□** Traditional treatments Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Currently taking **□** Not anymore

**□** Prayer **□** Currently taking **□** Not anymore

**□** Other Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Currently taking **□** Not anymore

**Have you ever had:**

**□** head CT Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ MRI Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ EEG Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family & Past Medical History

**Does anyone else in the family (blood relatives) have seizures?** Yes No

If yes, does *more than one* family member have seizures? Yes No

**Have you ever had a head injury with loss of consciousness?** Yes No

**Have you ever had a stroke?** Yes No

**Have you ever had a brain infection?** Yes No

**Have you ever been diagnosed with neurocysticercosis*?***  Yes No

**Do you drink alcohol?** Yes No

If yes, do you drink more than 2 alcoholic beverages a day? Yes No

If yes, do you drink more than 14 alcoholic beverages a week? Yes No

If yes, have you ever had a seizure after stopping drinking alcohol? Yes No

**What other medical problems do you have?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you on any other medications or treatments?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had any injuries related to seizures? (check all that apply)**

□ Burns

□ Breaking bones/fractures or bone dislocation

□ Head injury

□ Car accidents

□ Skin injury (scratches, cuts)

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you drive a car/motorcycle/truck?** Yes No

**For women: have you ever had a seizure during pregnancy?** Yes No

**For women: did you take anti-seizure medications while you were pregnant?** Yes No

**If yes, which medications?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_

Social networks and depression

Over the last 2 weeks, how often have you been bothered by any of the following problems

Not at all Several days More than half of days Nearly every day

0 1 2 3

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper of watching television
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual
9. Thoughts that you would be better off dead or of hurting yourself in someway

0 1 2 3

0 1 2 3

0 1 2 3

0 1 2 3

0 1 2 3

0 1 2 3

0 1 2 3

0 1 2 3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

How many *close friends* do you have, people that you feel at ease with, can talk to about private matters?

□ None

□ 1 or 2

□ 3 to 5

□ 6 to 9

□ 10 or more

□ Unknown

How many of these *close friends* do you see at least once a month?

□ None

□ 1 or 2

□ 3 to 5

□ 6 to 9

□ 10 or more

□ Unknown

How many *relatives* do you have, people that you feel at ease with, can talk to about private matters?

□ None

□ 1 or 2

□ 3 to 5

□ 6 to 9

□ 10 or more

□ Unknown

How many of these *relatives* do you see at least once a month?

□ None

□ 1 or 2

□ 3 to 5

□ 6 to 9

□ 10 or more

□ Unknown

Do you participate in any groups, such as a community center, social or work group, religious-connected group, self-help group, or charity, public service, or community group?

□ No

□ Yes

□ Unknown

About how often do you go to religious meetings or services

□ Never or almost never

□ Once or twice a year

□ Every few months

□ Once or twice a month

□ Once a week

□ More than once a week

□ Unknown

Is there someone available to you whom you can count on to listen to you when you need to talk?

□ None

□ 1 or 2

□ 3 to 5

□ 6 to 9

□ 10 or more

□ Unknown

Is there someone available to give you good advice about a problem?

□ None

□ 1 or 2

□ 3 to 5

□ 6 to 9

□ 10 or more

□ Unknown

Is there someone available to you who shows you love and affection?

□ None

□ 1 or 2

□ 3 to 5

□ 6 to 9

□ 10 or more

□ Unknown

Can you count on anyone to provide you with emotional support (talking over problems or helping you made a difficult decision)?

□ None

□ 1 or 2

□ 3 to 5

□ 6 to 9

□ 10 or more

□ Unknown

Do you have as much contact as you would like with someone you feel close to, someone in whom you can trust and confide?

□ None

□ 1 or 2

□ 3 to 5

□ 6 to 9

□ 10 or more

□ Unknown

**Economics**

**The following questions are designed for us to understand more about your financial situation, as this can affect the medical care that individuals are able to access. When asked for a monetary value please answer in Guinean Francs.**

Is there a head of the household? If so, what is their relation to you?

What is the highest education of the head of the household:

no school primary school lower secondary upper secondary university unknown

How many people are there in your household: \_\_\_\_\_\_\_\_

Number of adults 18 and over: \_\_\_\_\_\_

Number of adults who are working: \_\_\_\_\_\_\_

Number of adults who are not working: \_\_\_\_\_\_\_

Number of children: \_\_\_\_\_\_\_

Number of older (non-working) adults: \_\_\_\_\_\_\_

How much money have members of your household earned in the past month? \_\_\_\_\_\_\_\_

In a typical month, how much money does your household spend to cover all expenses including housing, food, schooling, and household goods? \_\_\_\_\_\_\_\_\_

In a typical month, how much does your household spend on food? \_\_\_\_\_\_\_\_

In a typical month, how much does your household spend on schooling? \_\_\_\_\_\_\_\_

In a typical month, how much does your household spend on treatment for epilepsy, including medications, visits to doctors, and traditional therapies? \_\_\_\_\_\_\_\_\_

Cost of Anti-epileptics \_\_\_\_\_\_\_\_

Cost of visits to doctors \_\_\_\_\_\_\_\_\_

Cost of traditional therapies \_\_\_\_\_\_\_\_

**What is the marital status of the head of the household?**

* Married or living together
* Divorced or separated
* Widowed
* Never married

**Is your mother currently alive?**

* Yes
* No

**Is your father still alive?**

* Yes
* No

**Where is the water supply?**

* In own dwelling
* In own yard/plot
* Elsewhere

**How long does it take you to go there, get water, and come back?**

Minutes: \_\_\_\_\_\_\_\_

[ ] Don’t know

**What is the main source of drinking water for members of your household?**

* Piped water (tap water)
  + Piped into dwelling
  + Piped into yard/plot
  + Piped into neighbor
  + Public tap/standpipe
* Tube well or borehole
* Dug well
  + Protected well
  + Unprotected well
* Water from spring
  + Protected spring
  + Unprotected spring
* Rainwater
* Tanker truck
* Cart with small tank
* Surface water (rivers/dams/lakes/ponds/rivers/canals/irrigation channel)
* Bottled water
* Other: \_\_\_\_\_\_\_\_\_\_\_

**What is the main source of water used by your household for other purposes such as cooking and handwashing?**

* Piped water (tap water)
  + Piped into dwelling
  + Piped into yard/plot
  + Piped into neighbor
  + Public tap/standpipe
* Tube well or borehole
* Dug well
  + Protected well
  + Unprotected well
* Water from spring
  + Protected spring
  + Unprotected spring
* Rainwater
* Tanker truck
* Cart with small tank
* Surface water (rivers/dams/lakes/ponds/rivers/canals/irrigation channel)
* Botteled water
* Other: \_\_\_\_\_\_\_\_\_\_\_

**In the past two weeks, was the water from this source not available for at least one full day?**

yes

no

I don’t know

**Do you do anything to the water to make it safer to drink?**

yes

no

I don’t know

**What do you usually do to make the water safer to drink? Please check all that apply**

Boil

Add Bleach/Chlorine

Strain through a cloth

Use water filter (ceramic/sand/composite/etc)

Solar disinfection

Let it stand and settle

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Don’t know

**What kinds of toilets to members of your household typically use?**

* Flush or pour flush
  + Connected to piped sewer system
  + Connected to a septic tank
  + Connected to a pit latrine
  + Connected to something else
  + I don’t know what it’s connected to
* Latrine
  + Ventilated improved pit latrine
  + Pit latrine with slab
  + Pit latrine without slab/open pit
* Composting toilet
* Buckets
* Hanging toilet/ Hanging latrinelatrines
* No toilets/bush/field
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you share this toilet with other households?

* Yes
* No

Including your own household, how many households use this toilet facility?

Number of households \_\_\_\_\_\_\_\_\_\_

More than 10

Not sure

Where is this toilet facility located?

In own dwelling

In own yard/plot

Elsewhere

**Does anyone in your household have a bank account?**

* Yes
* No

**Please check the box if you do have the following items in your household:**

* Electricity
* Radio
* Television
* Non-mobile telephone
* Computer

**Please check the box if any member of your household owns the following:**

* watch
* mobile phone
* Bicycle
* motor cycle or motor scooter
* Animal drawn cart
* Car or truck
* Boat with a motor

**Does your household have any mosquito nets?**

yes

no

**How many mosquito nets does your household have?**

**How many months ago did your household get the mosquito nets?**

months: \_\_\_\_\_\_

more than 36 months ago

not sure

**Did anyone from your household sleep under the mosquito net(s) last night? If so, who?**

**Where did you get your mosquito net from?**

Government health facility

Private health facility

Pharmacy

Shop/market

Religious institution

school

other

don’t know

Sleep Quality

How often during the past four weeks did you get enough sleep to feel rested upon waking up?

Never 1 2 3 4 5 Very often

**Stigma Scale of Epilepsy**

**Read each of the following questions and circle the number that best describes your opinion about epilepsy. Please use the following scoring system:**

Not at all……………………..1

A little………………………...2

A lot…………………….……...3

Totally………………………...4

Please be honest in your answers. Thank you for your cooperation.

**Question 1: Do you think that people with epilepsy feel able to control their own epilepsy?**

1

2

3

4

**Question 2: How would you feel when you see an epileptic seizure?**

1. **scared**

1

2

3

4

1. **fear**

1

2

3

4

1. **sadness**

1

2

3

4

1. **pity**

1

2

3

4

**Question 3: Which difficulties do you think people with epilepsy have in their daily lives?**

1. **Relationships**

1

2

3

4

1. **Work**

1

2

3

4

1. **school**

1

2

3

4

1. **friendships**

1

2

3

4

1. **sexual**

1

2

3

4

**f) emotional**

1

2

3

4

**g) prejudice**

1

2

3

4

**Question 4: How do you think that people with epilepsy feel?**

1. **Worried**

1

2

3

4

1. **dependent**

1

2

3

4

1. **incapable**

1

2

3

4

1. **fearful**

1

2

3

4

1. **ashamed**

1

2

3

4

1. **depressed**

1

2

3

4

1. **the same as those without epilepsy**

1

2

3

4

**Question 5: In your opinion, the prejudice in epilepsy will be related with:**

1. **relationships**

1

2

3

4

1. **marriage**

1

2

3

4

1. **work**

1

2

3

4

1. **school**

1

2

3

4

1. **family**

1

2

3

4

**Knowledge, Attitudes, and Beliefs Regarding Epilepsy**

We would like to talk with you about your experiences with epilepsy as part of our study on epilepsy in Guinea. We are interested in your understanding of your epilepsy. We are also interested in treatments you have tried for your epilepsy and what types of providers you have seen to treat your epilepsy. We hope that your answers to these questions will help us to better take care of people with epilepsy in the future.

**What are words or phrases that are used for your condition by members of your family or community? What do members of your community think is the cause of your epilepsy?**

**What do you think caused your epilepsy? Why do you think it started when it did?**

**Do you think your epilepsy is permanent? Can your epilepsy be cured?**

**What are the main problems your epilepsy has caused for you? What do you fear most about your epilepsy?**

**What happens when you have a seizure? What is a seizure? Can you tell when you are going to have a seizure?**

**What is your religion? What does your religion believe is the cause of your epilepsy?**

**What providers have you seen regarding treatment for your epilepsy (traditional healer, physician, etc)? Which of these providers is best able to treat your epilepsy?**

**What are types of treatment for epilepsy? Which treatments are most effective for epilepsy?**

**What is your desired outcome from treatment (symptom relief, cure, etc)?**

**What types of biomedical treatments have you received for your epilepsy? Where did you get these medications? Did these treatments work? Did these treatments harm you in any way, and if so, how?**

**What types of traditional treatments have you received for your epilepsy? Where did you get these treatments? Did these treatments work? Did these treatments harm you in any way, and if so, how?**

**Are there reasons you would not see a physician for your epilepsy?**

If you have any comments, please write them here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Thank you for completing the survey! If you have any questions about the survey, please ask the administrator, or other study personnel.

Version 2: September 12, 2017