Pediatric Neurology Patient Journal:
"Spells"

This Journal is a resource for you and your child's doctor to keep track of important information including: spell descriptions, spell frequency, time of day spells occur, triggers, and treatments.

Your child's journal is set up with the following sections: Spell History, Spell Report, Medication History and Questions for Your Child's Doctor. Please complete the journal to the best of your ability.

Personal Information

Child's Name: _____
Last First Middle

Child's Hospital ID Number: __ __ __ __ __ __ __ __

Child's Date of Birth:_____/___/_____

Allergies: _____

Parent or Guardian's Name _____

Parent or Guardian Phone Number __ __ __ - __ __ __ - __ __ __ __

Family Doctor or Pediatrician _____

Pediatrician's Phone Number __ __ __ - __ __ __ - __ __ __ __

"Spell" History

Child's age at the time of first spell: _____

What is the typical spell frequency? _____

What is the longest period without a spell? _____

If your child has had any of the following diagnostic test list date and results:

EEG: _____

CT: _____

MRI: _____

Other: _____

_____

_____

"Spell" Report

Type:
Please describe what your child's spell's look like. Describe what happens during a spell– please be as specific and detailed as possible.
(Example – "eye fluttering or brief loss of consciousness")

Before:
What typically happens before a spell? How does your child feel? Are there specific triggers? Please list for each spell type/description:

When:
When you're your child's spells tend to occur. Examples: occur when your child is wakes up in the morning, occur while awake and active, occur when child is falling asleep at night.

After
Describe what typically happens after each spell. Is your child confused? For how long? Does he or she sleep? For how long? Does he or she feel weak? How long does it take your child to fully recover?

Average Duration and Frequency

How long do your child's spells last in seconds or minutes?

How often does your child have these spells, number per day, week, or month on average?

Medication History

Please list any medications your child has received spells or seizures:

Drug Name	Dosage	Date started/stopped	Side Effects

Please list your child current medications:

Drug Name	Dosage	Date started/stopped	Reason for Use

Questions for my Doctor

1.

2.

3.

4.