

Seizure Risk to Seizure Reality:

Let's build your treatment plan together

This questionnaire is designed to work as a clickable PDF or a printout. As you fill this out, remember that there are no right or wrong answers when it comes to your experiences. Be sure to bring it to your doctor and discuss the right treatment plan for you.



Select one answer for each statement.

1. With the right treatment plan, I could become seizure-free.

Strongly agree Agree Don't know Disagree Strongly disagree

2. If side effects bother me, I will let my doctor know.

Strongly agree Agree Don't know Disagree Strongly disagree

3. A seizure can still happen even when treatment has been working.

Strongly agree Agree Don't know Disagree Strongly disagree

4. I have a schedule that rarely changes.

Strongly agree Agree Don't know Disagree Strongly disagree

5. I'm facing major life events (such as changes to relationships, moving, a new job).

Strongly agree Agree Don't know Disagree Strongly disagree

6. I have physical or emotional stress in my daily life.

Strongly agree Agree Don't know Disagree Strongly disagree

7. I have a support system in place with people who I trust to help me manage my epilepsy.

Strongly agree Agree Don't know Disagree Strongly disagree

8. I have sometimes missed doses or been late taking my medication(s).

Strongly agree Agree Don't know Disagree Strongly disagree

Select all that apply.

9. Select the obstacles below that could get in the way of your treatment.

- | | | |
|---|--|--|
| <input type="checkbox"/> I'm a caregiver | <input type="checkbox"/> I'm a single parent | <input type="checkbox"/> My job is stressful |
| <input type="checkbox"/> I'm in school | <input type="checkbox"/> I recently moved | <input type="checkbox"/> I don't always eat well |
| <input type="checkbox"/> I don't get enough sleep | <input type="checkbox"/> I struggle with my mental health | <input type="checkbox"/> I take other medication(s) |
| <input type="checkbox"/> I play video games | <input type="checkbox"/> I watch a lot of TV or movies | <input type="checkbox"/> I have difficulty paying for my medication(s) |
| <input type="checkbox"/> I drink alcohol or take other recreational drugs | <input type="checkbox"/> I have a busy or irregular schedule | <input type="checkbox"/> I have other physical/health issues |

Other:

Thank you for your responses

This information can help you and your doctor plan your treatment together.



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