Parents of Children with Epilepsy Questionnaire

If you have a child or family member who is experiencing seizures now, or has experienced seizures in the past, please answer the following questions. The goal is to assess your needs to determine how best to successfully provide help and support to your entire family. Include your name and contact information if you would be interested in learning more in the future.

1. What type of seizures does/did your child have? ______________________________________
   __________________________________________________________________________________

2. How old were they when the seizures began? _________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

3. When did a doctor diagnose them as seizures/epilepsy? _________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

4. Is there an identified cause for the seizures? If so, what is the cause? ______________________
   __________________________________________________________________________________

5. How did you discover your child was having seizures? What happens when they have a seizure?
   __________________________________________________________________________________
   __________________________________________________________________________________

6. How have they affected your life? ___________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

7. How have they affected your child’s life? _____________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

All information included in this survey is strictly confidential. If you are interested in receiving results, please include your contact information on the last page and they will be sent to you. Please return to Leigh Goldie at ellbee22@aol.com or mail to: 32342 Springside Lane, Solon, Ohio 44139. Please call 440-248-6158 with any questions. Thank you for your help!
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8. Is there anything specific that specifically causes them to have a seizure? ex: lights, sounds, smells, stress, lack of sleep, medication, etc?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

9. Do/did you have family members supporting you? How have they helped/handled the seizures?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

10. What is the most difficult part of their seizures for you?
________________________________________________________________________________
________________________________________________________________________________

11. At what hospital does their neurologist practice? What resources have they provided you with to learn more about epilepsy and seizures? (handouts, people to talk to, websites, online blogs, other resources)
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

12. Have you heard of the Epilepsy Association in Northeastern Ohio? Have you ever used their services?
________________________________________________________________________________
________________________________________________________________________________

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13. What are some ways an epilepsy group could help you and your family? ___________________
                                                                                         
                                                                                         
14. What are some topics you would like to learn more about? ______________________________
                                                                                         
                                                                                         
15. Check off the following topics/groups that would interest you or you would like to learn more about.

   _____ Peer Support Group   _____ Monitoring your child
   _____ Family Support Group   _____ Diet and Exercise with Epilepsy
   _____ Handling Seizures   _____ Reactions to seizures
   _____ Medication and side effects   _____ Handling seizures in public
   _____ Educating your child’s school/camp   _____ Seizures and personality
   _____ Educating your family/friends   _____ Seizures and depression/anxiety
   _____ Brain Surgery to stop seizures   _____ After Brain Surgery
   _____ Seizures and school work   _____ Seizures and Self Esteem
   _____ Seizures and Driving   _____ Types of seizures
   _____ Improving your mind, body and spirit

16. Would you be interested in becoming a peer mentor for someone just learning about their child’s seizures and needing to talk to someone who has experienced their child having seizures? __________
                                                                                         
                                                                                         
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17. Would you be interested in participating in any types of social groups / overnight camp groups for people with epilepsy? What types would best fit you? ___________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

18. Please list any other topics of interest, suggestions of ways you can help, or comments here: ________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Please include your contact information here if you would like updates on creating this organization. -
Note: including this information is optional, will remain strictly confidential and will not be shared without your consent.

Name: ________________________________________________________________________

Address: ____________________________________________________________________

________________________________________________________________________________

Phone Number: __________________________________________________________________

Email Address: __________________________________________________________________

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