

Infantile Spasms Log Sheet

Date: _____	Time: _____	Length: _____ min. _____ sec.	<input type="checkbox"/> Flag It
Number of spasms in cluster _____		Severity: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Less More	
Mood: <input type="checkbox"/> Good <input type="checkbox"/> Normal <input type="checkbox"/> Bad	OTC Medications _____		
Possible Triggers: <input type="checkbox"/> Changes in Medication (including late or missed)			
<input type="checkbox"/> Overtired or irregular sleep <input type="checkbox"/> Alcohol or drug use <input type="checkbox"/> Irregular Diet			
<input type="checkbox"/> Bright or flashing lights <input type="checkbox"/> Fever or overheated <input type="checkbox"/> Emotional Stress			
<input type="checkbox"/> Hormonal fluctuations <input type="checkbox"/> Sick – Describe _____			
<input type="checkbox"/> Other _____			
Trigger notes: _____			
Description: <input type="checkbox"/> Change in awareness <input type="checkbox"/> Loss of urine or bowel control			
<input type="checkbox"/> Loss of ability to communicate <input type="checkbox"/> Automatic repeated movements			
<input type="checkbox"/> Muscle stiffness in _____ <input type="checkbox"/> Aura			
<input type="checkbox"/> Muscle twitch in _____ <input type="checkbox"/> Other _____			
Description notes: _____			
Post event: <input type="checkbox"/> Unable to communicate <input type="checkbox"/> Remembers event			
<input type="checkbox"/> Sleepy <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Sleepy			
Post event notes: _____			
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