

Emily's Fund Client Intake Form

Date: _____

Client Information

Name: _____ Male Female

Address: _____

City/Province: _____ Postal Code: _____

Age Group: 0-12 13-18 19-64 65+ DOB: _____

Phone: _____ Email: _____

Relationship:

Self Parent Partner
 Friend/Co-worker Employer School/Teacher
 Other: _____

Referred to the Epilepsy South Eastern Ontario by: _____

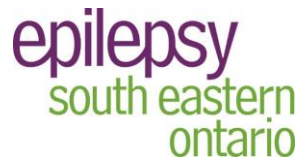
Medical History (self)

Age: _____ Family Physician: _____
Neurologist: _____

Type of Seizure(s):

Tonic Clonic Absence (PM) Myoclonic Atonic
 Focal dyscognitive (CP) Focal without impairment of consciousness (SP)
 Non-epileptic Unknown; please describe:

Medical history:



Reason for Contact:

Please check all that apply:

- Support Information Education Financial
 Employment Driving Newly Diagnosed Epilepsy Clinic
 Other; please specify:

Psychosocial History:

Comments:

Follow Up: _____

For Office Use Only

Handouts Provided:

Referrals:

Time spent on initial contact: min.

Staff Signature: _____

Date: _____

Level of service: Crisis (5) Counselling (4) Structured (3)
 Informal support/resources (2) Public awareness/education (1)

Add to Mailing List: Email Mail None