

# Epilepsy

Producer \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Client \_\_\_\_\_ Age/DOB \_\_\_\_\_ Sex \_\_\_\_\_

If your client has a history of Epilepsy, please answer the following:

1. Please list date of first diagnosis/type of seizure: \_\_\_\_\_

2. Please note type of seizure:

Complex/Partial Seizure

Tonic-Clonic Seizure

Absence Seizure

Myoclonic Seizure

3. Please indicate the number or frequency of episodes and date of last episode:

4. Is your client on any medications?

yes, please give details \_\_\_\_\_

no

5. Has your client been hospitalized for treatment of epilepsy?

yes, please give details \_\_\_\_\_

no

6. Has your client smoked cigarettes in the last 12 months?

yes, please give details \_\_\_\_\_

no

7. Does your client have any other major health problems (ex: heart disease, etc.)?

yes, please give details \_\_\_\_\_

no