Dietary Therapies for Epilepsy Program

Intake Form

Child's name:	☐ M ☐ F
Parent(s) name:	
Date of birth:	**Today's date:**
Address:	
Telephone number:	**Email address:**
Health insurance company:	
Member number:	**Group number:**
Primary carrier or insurance:	
Primary care provider (name and phone number):	
Primary neurologist (name and phone number):	
Pharmacy (phone number, location):	
Family Case Worker (name and phone number):	

Growth History

Child's weight:	**Child's height:**

Has there been any recent change in your child's weight? If yes, please explain:

How would you describe your child's level of physical activity?

Medication and Vitamin/Supplement History

Medications and vitamins/supplements your child is currently taking (you can attach a list if you prefer):

Name	Dose	Form	Timing	Manufacturer

Diet/Food History *(please see below if your child is exclusively tube fed)*

How would you describe your child's usual appetite?

☐ **Great** ☐ **Good** ☐ **Fair** ☐ **Poor** ☐ **Unsure** *(exclusively tube-fed)*

How would you describe your child's level of openness to trying new foods? (Is your child a "picky" eater, only willing to eat certain foods?)

Does your child have any allergies, sensitivities or sensory issues related to food? Are there any issues with chewing or swallowing? If yes, please describe

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Does your child use a:
☐ Sippy cup ☐ Regular cup ☐ Bottle ☐ Does not drink by themselves

Describe a typical day's diet (food and beverages):
Breakfast-

Lunch-

Dinner-

Snacks-

Does your child attend day care or school? If so, do they eat any meals provided by the school or do they bring food from home?

Enteral Feeding History

What kind of feeding tube does your child have?
☐ Gastrostomy ☐ Nasogastric tube ☐ Jejunostomy ☐ Other: _____

How long has your child had a feeding tube?

What led to the placement of this tube?

Please tell us about your child's feeding schedule and flushes:

Formula name	Time	Amount of formula	Amount of water

Are there any formulas that you child did not tolerate?

Which home care service do you use to receive your feeding supplies? Please list the phone and fax numbers:

Do we have your permission to contact them about formula changes or supplies?
☐ Yes ☐ No

Bowel habits:
☐ Normal ☐ Constipation ☐ Loose stools

Seizure history:

Previous seizure medications (not listed above) and why discontinued (not effective or side effects):

Family medical history:
☐ Heart disease or stroke ☐ High cholesterol or lipids ☐ Kidney stones


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