John A. Schafer, MD
Multiple Sclerosis
Achievement Center

Dignity Health.
Neurological Institute
of Northern California

JOHN A. SCHAFER, MD MULTIPLE SCLEROSIS ACHIEVEMENT CENTER

7777 Greenback Lane, Suite 108
Citrus Heights, CA 95610
(916) 453-7966- phone
(916) 851-7636- fax

Thank you for your interest in the John A. Schafer, MD Multiple Sclerosis Achievement Center's wellness program. Our wellness programs are designed to address different aspects of wellness including physical, cognitive and emotional/social wellness. Participants will attend one-day per week and participate in structured activities. Enclosed is our program application. Please complete the application and return it to me at the following address:

MS Achievement Center
7777 Greenback Lane, Suite 108
Citrus Heights, CA 95610
Or
Fax to: (916) 851-7636
Or
Email: tiffany.malone@commonspirit.org

You are asked to share information about your health and wellness history and to identify some of the goals you may have regarding your participation in the program. Please answer the questions as honestly and completely as possible. Your answers will not impact whether we move forward to the next step of enrollment.

Once the application is reviewed, you will be contacted to schedule a short meeting to further discuss the information you have provided. During that meeting, if it is mutually agreed that the one-day per week wellness program is appropriate for you, we will proceed with the next step in the enrollment process.

If you have any questions, please contact me at (916) 453-7966.

Sincerely,

Tiffany Malone, MSW, MSCS
Director

John A. Schafer, MD
Multiple Sclerosis
Achievement Center

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of Northern California

PROGRAM APPLICATION

Name:_____Date_____

Address:_____

City_____State_____Zip Code_____

Phone: *Home*_____*Business*_____*Cell*_____

Email address:_____

*Preferred method of communication: ☐ home phone ☐ cell phone ☐ e-mail

Assigned Gender at Birth: ☐ Female ☐ Male

Identified Gender: ☐ Female ☐ Male ☐ Genderqueer/Non-binary

Identified Pronoun: ☐ She/Her ☐ He/Him ☐ They/Them

Date of Birth_____

Emergency Contact:_____
name/relationship preferred contact (phone or e-mail)

Who referred you to the MS Achievement Center?_____

Where do you get the majority of your information about MS (i.e. healthcare provider, online resources, books/magazines)?

_____

SOCIAL INFORMATION

Marital Status: ☐ Single (never married) ☐ Married ☐ Separated ☐ Domestic Partner
☐ Divorced ☐ Widowed ☐ Other_____

Who lives with you at the present time? (please include ages of children)

_____

Type of Residence: ☐ House ☐ Condo/Townhouse ☐ Apartment
Other (please explain):_____

Home Accessibility:

Stairs into home: # of Stairs _____ # of Handrails _____

Stairs within home: # of Stairs_____ # of Handrails _____

☐ Elevator ☐ Outdoor Ramp ☐ Indoor Ramp ☐ Other _____

Transportation:

☐ Self (please describe any adaptations)_____

☐ Family or Friend (name and phone #)_____

☐ Public transportation ☐ Paratransit ☐ Other _____

EMPLOYMENT INFORMATION

Current employment status:

☐ Full time ☐ Part time ☐ Part time due to MS ☐ Student

☐ Unemployed ☐ Unemployed due to MS ☐ Retired ☐ Retired due to MS

Other_____

MEDICAL INFORMATION

Primary Care Physician_____

Address_____

City_____State_____Zip_____

Phone_____Fax_____

Neurologist_____

Address_____

City_____State_____Zip_____

Phone_____Fax_____

Insurance Information: PPO_____ HMO_____

☐ Medicare ☐ Medi-Cal ☐ VA ☐ None

Do you qualify for veteran benefits? ☐ No ☐ Yes

Date of onset of Initial MS Symptoms_____

Date of MS Diagnosis_____

Does anyone else in your family have MS? ☐ No ☐ Yes- Whom?_____

The following is a list of symptoms some people with MS have experienced. Not everyone who has MS experiences these symptoms. Please check off only the symptoms you are **currently** experiencing:

☐ Visual Changes ☐ Bladder Problems ☐ Pain ☐ Spasticity
☐ Bowel Problems ☐ Tremors ☐ Weakness ☐ Heat Sensitivity
☐ Fatigue ☐ Speech Changes ☐ Swallowing Changes ☐ Sensory Changes
☐ Memory Change ☐ Impaired Coordination ☐ Impaired Balance
☐ Falls (how many in the last six months)_____
☐ Other Cognitive Changes_____
☐ Emotional changes (sadness, hopelessness, change in appetite or sleep)

Describe_____

Other (describe)_____

List the areas that are the most challenging to you in respect to MS:

_____

_____

_____

List any mobility devices you currently use (walking aids such as cane, walker and braces, as well as, wheelchairs, scooter, etc):

_____

List any other assistive devices you currently use:
☐ Grab bars at toilet ☐ Raised toilet seat ☐ Sliding board
☐ Hoyer lift ☐ Indwelling (Foley) catheter ☐ Intermittent catheter
☐ Glasses/contact lenses ☐ Hearing aid(s)

Please list any other medical problems:

_____

_____

Allergies: ☐ None ☐ Food ☐ Drug ☐ Iodine ☐ Latex ☐ Seasonal

Other_____

MEDICATIONS

Please list all prescribed medications, over the counter medications, vitamins, supplements:

Name	Dosage	How Often?	Purpose

EXERCISE HISTORY

Please indicate your current exercise activities below:

Activity	Distance/Duration	Frequency per Week

If you do not currently exercise, have you exercised in the past? ☐ No ☐ Yes

If yes,

What did you do for exercise?_____

When did you stop exercising?_____

Why did you stop exercising?_____

Why did you choose to apply for this program? (use back of application if necessary)

_____

_____

_____

Please state one to three personal goal(s) that you would like to accomplish in this program:

1. _____

2. _____

3. _____

The information contained in this application is accurate to the best of my knowledge.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Person Completing Form
(If different than the applicant) Date

Please return this application to:

Tiffany Malone
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Citrus Heights, CA 95610
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or EMAIL to: tiffany.malone@commonspirit.org