MULTIPLE SCLEROSIS ACHIEVEMENT CENTER
ACHIEVING WELLNESS REGISTRATION FORM

Name:____Date__________

Address:____

City________________________State__________Zip Code____________

Phone: *Home*_____________*Business*____________*Cell*_______________

Preferred e-mail address:____

*Please indicate your preferred method of communication (e.g. home phone, cell phone, e-mail,)____

Gender: ☐ Female ☐ Male Date of Birth____/____/____

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

How did you hear about the Achieving Wellness Program?______________________

How would you rate your overall knowledge about MS?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

How would you rate your overall level of wellness?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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

SOCIAL INFORMATION

Do you or have you ever used tobacco? ☐ Yes ☐ No ☐ Currently
If yes, indicate type, amount and length of time:___________________________

Do you consume alcohol? ☐ Yes ☐ No
If yes, indicate type, amount and for how long:________________________________

Total years of formal education (please list total years and degrees obtained):

____

Marital Status (please circle): Single (never married) Married Separated

Domestic Partner Divorced Widowed Other__________________

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

Transportation:

☐ Self (please describe any adaptations)__________________________________

☐ Family or Friend (name and phone #)___________________________________

☐ Public transportation ☐ Paratransit ☐ Other____________________

EMPLOYMENT INFORMATION

What is your current employment status?
☐ Full time ☐ Part time ☐ Part time due to MS ☐ Student
☐ Unemployed ☐ Unemployed due to MS ☐ Retired ☐ Retired due to MS
☐ Other____

Describe any problems your MS is causing in terms of your work or school

____

MEDICAL INFORMATION

Primary Care Physician____

Address____

City____________________________State____________Zip____________________

Phone____________________________Fax________________________________

Neurologist____

Address____

City____________________________State____________Zip____________________

Phone____________________________Fax________________________________

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 **<u>currently</u>** 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)____

Please indicate any **changes** in your MS symptoms you have noticed in the **last 6 months:**

____

List up to 3 areas that are the most challenging to you in respect to MS:

1.

2.

3.

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 ☐ Grab bars in tub/shower

☐ Shower chair ☐ Tub bench ☐ Hand-held shower hose

☐ Sliding board ☐ Hoyer lift ☐ Hospital bed

☐ Indwelling (Foley) catheter ☐ Intermittent catheter

☐ Glasses/contact lenses ☐ Hearing aid(s)

Do you have any other medical problems? ☐ Yes ☐ No

If yes, please describe any other medical problems:

Please list all hospitalizations, operations and injuries (please include dates, if possible):

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

Other____

Please describe:____

MEDICATIONS

Are you currently taking any MS disease modifying medications? ☐ Yes ☐ No

Which medication are you taking?____

Please list any additional prescribed medications:

Name of Medicine	Dosage	How Often?	Purpose

Please list any over the counter medicines, vitamins, herb and supplements:

Name	Dosage	How Often?	Purpose

NUTRITION HISTORY

Dietary Restrictions:

☐ None ☐ Diabetic ☐ Gluten free ☐ Low fat ☐ Low sodium

☐ Other____

Please list your favorite foods and beverages:______________________________

____

EXERCISE HISTORY

Do you currently exercise? ☐ Yes ☐ No

If yes, please indicate your current activities below:

Activity	Distance/Duration	Frequency per Week
____________________	____________________	____________________
____________________	____________________	____________________

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

If yes,

What did you do for exercise?______________________________

When did you stop exercising?______________________________

Why did you stop exercising?______________________________

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 Date
(If different than the applicant)

Please return this registration form to:

Tiffany Malone
7777 Greenback Lane, Suite 108
Citrus Heights, CA 95610
or FAX to: (916) 851-7636