Dignity Health.

MULTIPLE SCLEROSIS ACHIEVEMENT CENTER
EMPOWERED TO ACHIEVE PROGRAM APPLICATION

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)

Who referred you to the MS Achievement Center?_____

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

Where do you get the majority of your information about MS?
☐ Health care provider ☐ Books /Magazines ☐ Internet (please list websites)

_____

☐ MS organizations (please list)_____

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)

Type of Residence: ☐ House ☐ Condo/Townhouse ☐ Apartment

☐ Other (please explain):_____

Home Accessibility:

☐ Stairs into home: # of Stairs _____Handrail ☐ Yes ☐ No #_____

☐ Stair within home: # of Stairs_____Handrail ☐ Yes ☐ No #_____

☐ Elevator ☐ Ramp ☐ Outdoor ☐ Indoor ☐ Other_____

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_____

Insurance Information: ☐ PPO_____ ☐ HMO_____
☐ Medicare ☐ Medi-Cal ☐ None
☐ Other_____

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)_____

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 (If different than the applicant) Date

Please return this application to:

Brian Hutchinson
7777 Greenback Lane, Suite 108
Citrus Heights, CA 95610
or FAX to: (916) 858-7174