



MULTIPLE SCLEROSIS ACHIEVEMENT CENTER 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:

- | | | |
|-----------------------------------------|------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Visual Changes | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Spasticity | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Heat Sensitivity | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Speech Changes | <input type="checkbox"/> Swallowing Changes | <input type="checkbox"/> Sensory Changes |
| <input type="checkbox"/> Memory Change | <input type="checkbox"/> Impaired Coordination | <input type="checkbox"/> 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:

<u>Name of Medicine</u>	<u>Dosage</u>	<u>How Often?</u>	<u>Purpose</u>
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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