John A. Schafer, MD
Multiple Sclerosis
Achievement Center

Dignity Health.
Neurological Institute
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?_____

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)_____

SOCIAL INFORMATION

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, herbs and supplements:

Name	Dosage	How Often?	Purpose

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?_____

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 Date
(If different than the applicant)

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