For Internal Use Only
Intake: ____/____/____
Start: ____/____/____

MSAC *REACH to Achieve Program* Member Application

Name: _____ Date:_____

Address:_____

City: _____State: ____ Zip: _____

Phone: *Home*_____ *Work*_____ *Cell* _____

E-mail address:_____Fax: _____

Gender: ❑ Male ❑ Female Handedness: ❑ Left ❑ Right ❑ Both

Date of Birth:___/___/_____

Emergency Contact:_____
(name/relationship) (phone #)

SOCIAL INFORMATION

Place of Birth:_____

Do you use tobacco? ❑ Yes ❑ No
If yes, indicate type, amount and for how long:_____

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

Total years of Formal Education:
❑ Grade School (1-8) ❑ High School (9-12) ❑ College (13-16)
❑ Masters (17-18) ❑ Doctorate (19-20)

Marital Status:
❑ Single (never married) ❑ Married ❑ Domestic Partner
❑ Separated ❑ Divorced ❑ Widowed
❑ Other: _____

Who lives with you at the present time?
❑ Spouse/Domestic Partner ❑ Children Age(s):_____ ❑ Parent(s)
❑ Brothers +/or Sisters ❑ Other Relatives ❑ Friends
❑ Live Alone ❑ Other:_____

Type of Residence:
❑ House ❑ Condo/Townhouse ❑ Apartment ❑ Other:_____

Home Accessibility:
❑ Stairs into home # of Stairs:____ Railing ❑ Yes ❑ No
❑ Stairs within home # of Stairs:____ Railing ❑ Yes ❑ No
❑ Elevator ❑ Ramp ❑ Other (describe):_____

Transportation:
❑ Self ❑ Family/Friend (name and phone #):_____
❑ ACCESS (ID#):_____ ❑ City Ride ❑ Public Transportation
❑ Other (describe):_____

EMPLOYMENT INFORMATION

Have you ever held a job? ❑ Yes ❑ No

What is your current employment status?
❑ Employed full-time ❑ Unemployed ❑ Retired
❑ Employed part-time ❑ Unemployed due to MS ❑ Retired due to MS
❑ Employed part-time due to MS ❑ Student
❑ Other:_____

If employed, what kind of work do you do?_____

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

_____

_____

MEDICAL INFORMATION

Insurance Info: ❑ PPO/POS _____ ❑ HMO_____
❑ Medicare ❑ Medi-Cal
❑ Other_____ ❑ None

Primary Care Physician:_____

Address:_____

City: _____State: ____ Zip: _____

Phone:_____FAX: _____

Neurologist:_____

Address:_____

City: _____State: ____ Zip: _____

Phone:_____FAX: _____

Date of onset of Initial Symptoms of MS:_____

Date of MS Diagnosis:_____

Does anyone else in your family have MS? ❑ No ❑ Yes If Yes, whom?_____

The following is a list of symptoms some people with MS have experienced. Not everyone who has MS experiences these symptoms so please do not read anything into this list. Please check off only the symptoms you are **currently** experiencing:

- ❑ Visual Changes
- ❑ Changes in Sensation
- ❑ Pain
- ❑ Tremors
- ❑ Spasticity (muscle stiffness)
- ❑ Impaired Coordination
- ❑ Muscle Weakness
- ❑ Impaired Balance/Dizziness
- ❑ Bladder Problems
- ❑ Bowel Problems
- ❑ Changes in Sexual Function
- ❑ Fatigue
- ❑ Heat Sensitivity
- ❑ Changes in Speech/Swallowing
- ❑ Memory or other Cognitive Changes
- ❑ Falls in Last 6 Months How Many?___
- ❑ Emotional Changes (feelings of sadness, hopelessness, changes in appetite/sleep) (describe):_____

- ❑ Other (describe):_____

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

_____

_____

List the **3 areas that are the most challenging** to you in respect to MS (list the most challenging area first):

1.
2.
3.

List any mobility devices you currently use:

❑ Single point cane ❑ 4-prong cane ❑ Pick up walker ❑ Front-wheeled walker
❑ 4-wheeled walker ❑ Manual wheelchair ❑ Power wheelchair ❑ Scooter
❑ Lofstrand crutches ❑ Axillary crutches ❑ Ankle Foot Orthosis (AFO)
❑ Other (describe):_____

List any other assistive equipment you currently use:

- ❑ Glasses/contact lenses
- ❑ Grab bars at toilet
- ❑ Raised toilet seat
- ❑ Commode chair
- ❑ Indwelling (Foley) catheter
- ❑ Intermittent catheter
- ❑ Sliding board
- ❑ Hoyer lift
- ❑ Hospital bed
- ❑ Hearing aid(s)
- ❑ Grab bars in tub/shower
- ❑ Shower chair
- ❑ Tub bench
- ❑ Hand-held shower hose
- ❑ Long-handled sponge
- ❑ Other (describe):

_____

_____

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

If yes, check all that apply:

- ❑ Abnormal Bleeding
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Osteoporosis
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Other _____
- ❑ Heart Disease: ❑ Heart Attack ❑ Chest Pain ❑ Irregular Heart Beats ❑ Fainting

Please list all hospitalizations, operations and injuries including broken bones (include dates):

Allergies: ❑None ❑Drug ❑Food ❑Iodine ❑Latex ❑Other_____

Describe: _____

_____

MEDICATIONS:

Are you currently taking any of the **MS treatment** medications? ❑ Yes ❑ No

If yes, please check: ❑ Aubagio ❑ Avonex ❑ Betaseron/Extavia ❑ Copaxone/Glatopa ❑ Gilenya ❑ Lemtrada ❑ Plegridy ❑ Rebif ❑ Tecfidera ❑Tysabri ❑ Other:_____

Current Prescribed Medications:

Name	Dosage	How Often?	Purpose

Over the Counter Medications, Vitamins, Herbs and Supplements:

Name	Dosage	How Often?	Purpose

NUTRITION HISTORY

Dietary restrictions:

❑None ❑Diabetic ❑Low sodium ❑Low fat ❑Other_____

Please list your favorite foods and beverages: _____

_____

_____

Using the space below, record a detailed description of the times, types and amounts of all foods and beverages consumed during a **typical** weekday. Be as descriptive as possible and note the amount and method of preparation where appropriate.

Time/Food/Beverage Item	Serving Size/Amount
Breakfast	
Lunch	
Dinner	
Snacks	

EXERCISE HISTORY

Do you currently exercise? ❑ Yes ❑ No

If yes, please indicate your current exercise program:

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? _____

How would you rate your overall knowledge about MS:

❑ Poor ❑ Fair ❑ Good ❑ Very Good ❑ Excellent

How would you rate your overall level of wellness:

❑ Poor ❑ Fair ❑ Good ❑ Very Good ❑ Excellent

Why are you choosing to come to this program?

Please state one (or more) personal goal(s) that you would like to accomplish in this program.

1.

2.

3.

Functional Abilities

Please check off the level of difficulty, if any, you have with the following activities:

1) **Stair Climbing.** Walking up and down a flight of 12 stairs.
- ❑ Unable to perform
- ❑ Need human assistance to perform
- ❑ Need cane, brace or railing to perform
- ❑ Some difficulty, but performed without aid
- ❑ No difficulty, able to perform without railing

2) **Mobility.** Walk 150 feet without rest on level ground or indoors.
- ❑ Unable to perform or requires someone to push manual wheelchair or requires power wheelchair to perform
- ❑ Need human assistance or can use manual wheelchair independently to perform
- ❑ Need cane, brace or walker to perform
- ❑ Some difficulty, but performed without aid
- ❑ No difficulty

3) **Transfers.** Transfer to and from toilet, chair, wheelchair and bed.
- ❑ Must be lifted or moved about completely by another person or by equipment
- ❑ Need human aid to perform
- ❑ Need adaptive or assistive devices such as grab bars, sink or sliding board
- ❑ Some difficulty but performed without aid
- ❑ No difficulty

4) **Bowels.** Able to manage constipation and control bowels.
- ❑ Has frequent loss of bowel control
- ❑ Need enemas or suppositories administered by another, or has occasional bowel incontinence
- ❑ Need regular (more than once per week) laxatives, enemas or suppositories that are self-administered
- ❑ Some difficulty requiring high fiber diet or occasional laxatives, enemas or suppositories
- ❑ No difficulty

5) **Bladder.** Able to control bladder function.
- ❑ Frequent loss of bladder control (incontinence)
- ❑ Occasional incontinence and/or use of indwelling catheter or external catheter applied or maintained by others; and/or intermittent catheterization performed by others
- ❑ Frequent hesitancy, urgency or retention*, and/or use of indwelling or external catheter applied or maintained by self, and/or intermittent catheterization by self
  **hesitancy is difficulty initiating urination; urgency is need to urinate immediately; retention is inability to empty bladder completely*
- ❑ Occasional hesitancy or urgency
- ❑ No difficulty (even if maintained by medication)

6) **Bathing.** Able to transfer in and out of tub or shower and bathe self.
- ❑ Unable to perform
- ❑ Need human assistance to transfer or to bathe
- ❑ Need assistive devices (shower chair, tub bench, grab bars) to bathe self
- ❑ Some difficulty with washing and drying self but able to perform without aid either in tub, shower or by sponge bathing
- ❑ No difficulty

7) **Dressing.** Able to dress and undress using standard clothing and shoes.
- ❑ Unable to dress self
- ❑ Need human assistance, but performs most of activity independently
- ❑ Need specifically adapted clothing or shoes (no buttons, front-closing garments, no zippers, Velcro closures) or avoids certain types of standard clothing or shoes, or uses devices (long shoe horns, button hook, zipper extenders) to dress self
- ❑ Some difficulty dressing self in standard clothing, but able to perform by self
- ❑ No difficulty

8) **Grooming.** Able to brush teeth, comb hair, shave and apply cosmetics.
- ❑ Almost all tasks are performed by another
- ❑ Need human assistance to perform some tasks
- ❑ Need for adaptive devices (electric razor or toothbrush, special combs or brushes, arm supports) but able to perform without assistance
- ❑ Some difficulty, but all tasks performed without aid
- ❑ No difficulty

9) **Feeding.** Able to use standard utensils to feed self and consume solids and fluids.

- ❑ Unable to feed self
- ❑ Need human assistance to eat or requires modified diet (thickened liquids, pureed foods)
- ❑ Need for adaptive devices (special utensils, plates, cups, straws) or special preparation (cut up foods, butter bread, open containers)
- ❑ Some difficulty, but able to perform by self
- ❑ No difficulty

10) **Vision.** Able to read print finer than standard newspaper print with glasses if needed.

- ❑ Legally blind
- ❑ Can only read VERY large print such as headlines, or has constant double vision, or objects seem to move when looking at them
- ❑ Need magnifying lenses or large print to read, or double vision interferes with seeing
- ❑ Cannot read print finer than standard newspaper print even with glasses, or complains of double vision
- ❑ No difficulty; can read print finer than standard newspaper print with glasses if needed

11) **Speech and Hearing.** Able to speak and hear clearly for communication with others.

- ❑ Severe deafness and/or slurred speech without techniques or aids to effectively compensate.
- ❑ Severe deafness and/or slurred speech that is managed using sign language or self-written communication
- ❑ Moderate hearing loss requiring hearing aid and/or moderate slurred speech that interferes with communication, and/or needs communication aids such as special keyboards
- ❑ Mildly impaired hearing or speech that does not interfere with communication
- ❑ No difficulty with hearing, speech or communication

12) **Mood and Thought Problems.** Includes feeling sad or blue, nervous or tense, rapid mood swings and/or angry outbursts.

- ❑ Mood or thought problem severely interferes with day-to-day functioning
- ❑ Mood or thought problem moderately interferes with day-to-day functioning and requires medications and/or on-going assistance of psychiatrist, psychologist, social worker or counselor
- ❑ Mood or thought problem mildly interferes with day-to-day functioning but can be managed with medications and/or assistance of mental health professionals
- ❑ Occasional mood or thought difficulty, but does not interfere with day-to-day functioning
- ❑ No difficulty

13) **Intellectual Functions.** Includes memory, reasoning, calculation, judgment and orientation to perform everyday activities.

- ❑ Severe confusion, disorientation or memory loss that prevents performance of most everyday activities
- ❑ Need to be prompted or assisted by others to perform everyday activities
- ❑ Need to use lists or other cues to perform everyday activities, but able to do so without help of others
- ❑ Mild difficulty, but does not interfere with everyday activities
- ❑ No difficulty

14) **Fatigue.** Overwhelming weakness or loss of energy that interferes with physical function.

- ❑ Fatigue prevents prolonged physical function
- ❑ Causes frequent problem with physical function
- ❑ Causes mild or passing problem with physical function
- ❑ Present, but does not interfere with physical function
- ❑ No fatigue

15) **Sexual Activity and Function.** Ability to engage in acts that cause a sexual response.

- ❑ Sexually inactive and not concerned
- ❑ Sexually inactive, but wishes to regain previous pattern and ability
- ❑ Sexually less active than before, and now experiencing some sexual problems; wishes to regain previous pattern and ability
- ❑ Sexual less active than before and/or now experiencing some sexual problems, but not concerned
- ❑ Sexually active as before and/or not experiencing sexual problems

16) Do you have a caregiver? ☐ Yes ☐ No If yes, please indicate number of hours per day and types of assistance caregiver provides:

_____

_____

_____

Please FAX application to:
Marilyn Hilton MS Achievement Center at (310) 267-4075
or
MAIL to: Executive Director, Marilyn Hilton MS Achievement Center at UCLA, 1000 Veteran Ave., Ste. 11-62, Box 714722, Los Angeles, CA 90095-7147

For Internal Use Only: B/P:_____ Pulse: _____ Height:_____ Weight:_____ EDSS_____