Intake Form: Multiple Sclerosis

Chief Complaint

In your own words, what brings you in today?

_____

_____

History of Present Illness (HPI)

Briefly describe your present symptoms:

_____

_____

Date symptoms began? _____

Describe the frequency of the problem *(continuous, intermittent, daily, hourly etc.)*:

_____

On a scale from 0 to 10, 0 being no problem at all and 10 being severe as possible, how would you rate it? _____

What body parts are most affected? _____

Have you previously received a diagnosis for this problem? *(circle one)* **Yes** **No**

If so, what was the diagnosis:_____

Who made the diagnosis:_____

What tests have been performed to evaluate this problem *(i.e. MRI, lab tests, etc.)*?

_____

_____

What treatments have been tried for this problem *(i.e. medications, physical therapy, etc.)*?

_____

_____

What improves the problem *(medication, rest, sitting, etc.)*?

_____

_____

What worsens the problem *(exercise, poor sleep, stress, etc.)*?

_____

_____

Has your problem interfered with your activities of daily living, such as bathing, feeding, or clothing yourself, or has it impacted your occupation? If so, what?

_____

_____

Who in your family has a similar problem?

_____

Are you interested in participating in research trials? *(circle one)* **Yes** **No** **Maybe**

Surgical History ☐ No prior surgeries or procedures

Procedure	Date (MM/YYYY)	Complications?

Review of Systems

Constitutional ☐ None of the below

☐ Fever / Chills
☐ Unintentional weight gain / loss
☐ Exercise intolerance
☐ Fatigue
☐ Night sweats
☐ Inability to sleep
☐ Sleeping too much

HEENT ☐ None of the below

☐ Blurred vision / vision loss
☐ Hearing change
☐ Nosebleeds
☐ Difficulty chewing / swallowing
☐ Change in smell / taste
☐ Double vision
☐ Ringing in the ears
☐ Hoarseness / prolonged sore throat
☐ Speech changes / difficulty
☐ Snoring

Respiratory ☐ None of the below

☐ Shortness of breath
☐ Wheezing
☐ Chronic cough

Cardiovascular ☐ None of the below

☐ Chest pain / pressure / heaviness
☐ Swelling of feet / ankles
☐ Palpitations
☐ Fainting spells

Gastrointestinal ☐ None of the below

☐ Nausea / Vomiting
☐ Constipation
☐ Diarrhea
☐ Heartburn / Indigestion
☐ Abdominal pain
☐ Blood in stool

Genitourinary ☐ None of the below

☐ Pain or burning with urination
☐ Blood in urine
☐ Sexual dysfunction / impotence
☐ Frequent urination
☐ Change in menstrual cycle

Neurologic ☐ None of the below

☐ Headache
☐ Numbness / Tingling
☐ Involuntary movements / tremor / twitching / cramps
☐ Memory loss
☐ Poor balance / falls
☐ Seizures / Convulsions

Psychiatric ☐ None of the below

☐ Mood change
☐ Depression
☐ Anxiety
☐ Hallucinations
☐ Paranoia
☐ Delusions

Endocrine ☐ None of the below

☐ Heat or cold intolerance
☐ Excessive sweating
☐ Excessive thirst / urination
☐ Hair change

Hematologic/Immune ☐ None of the below

☐ Easy bruising or bleeding
☐ Swollen lymph nodes

Musculoskeletal ☐ None of the below

☐ Joint pain
☐ Neck pain +/- shooting pain into arms
☐ Low-back pain +/- shooting pain into legs

Multiple Sclerosis Questionnaire

*Please complete **ONLY** if you have a known or possible diagnosis of Multiple Sclerosis*

How many flare-ups of symptoms/exacerbations have you had in the last year? _____

Are you currently on an MS therapy drug? *(circle one)* **Yes** **No**

If so, which one: _____

Symptom Profile

Please rate average symptoms over the last 30 days. Please only check one box for each symptom.

	None	Mild	Moderate	Severe
Fatigue	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Muscle Spasms	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐
Numbness	☐	☐	☐	☐
Memory/Thought Process	☐	☐	☐	☐
Imbalance	☐	☐	☐	☐
Pain	☐	☐	☐	☐
Loss of Vision	☐	☐	☐	☐
Double Vision	☐	☐	☐	☐
Blurred Vision	☐	☐	☐	☐
Difficulty Swallowing	☐	☐	☐	☐
Slurred Speech	☐	☐	☐	☐
Bladder Dysfunction	☐	☐	☐	☐
Bowel Dysfunction	☐	☐	☐	☐
Sexual Dysfunction	☐	☐	☐	☐
Heat Sensitivity	☐	☐	☐	☐