

Intake Form: Multiple Sclerosis

Briefly describe what brings you in for today's visit

Date symptoms began? _____

Have you been given a diagnosis for these symptoms? If so, what diagnosis was given?

What tests have been performed to evaluate this problem (i.e. MRI, lab tests, etc.)? *Please note when and where these tests were completed*

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

List other physicians you have seen for this problem:

Would you be interested in participating if a research study were available? (circle one) **Yes** **No** **Maybe**

Surgical History No prior surgeries or procedures

Procedure	Date (MM/YYYY)	Complications?

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
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory/Thought Process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slurred Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>