MULTIPLE SCLEROSIS (MS) QUESTIONNAIRE

Client ____ Age/DOB _________________

When was MS first diagnosed? ___________
Date of last symptoms, attack, exacerbation or flare? ____________
Frequency of attacks, exacerbations or flares? __________________________________

Check type of MS:

- ☐ RELAPSING REMITTING
- ☐ SECONDARY PROGRESSIVE
- ☐ PROGRESSIVE RELAPSING
- ☐ PRIMARY PROGRESSIVE

Check severity of MS:

- ☐ MILD
- ☐ MODERATE
- ☐ SEVERE
- ☐ EXTREME

Do you know your EDSS score (Expanded Disability Status Scale)? YES ☐ NO ☐
If yes, please enter number here:_________

Check any symptoms exhibited in past year:

- ☐ Optic Neuritis (visual disturbance)
- ☐ Numbness or pins & needles
- ☐ Pain
- ☐ Diplopia (double vision)
- ☐ Weakness
- ☐ Ataxia (lack of coordination of muscle movements)
- ☐ Paraparesis (partial paralysis of lower limbs)
- ☐ Spasticity (decreased motor control)
- ☐ Fatigue
- ☐ Mood swings or depression
- ☐ Lhermitte's sign (electrical sensation down back into limbs)
- ☐ Dysarthria (motor speech disorder)
- ☐ Swallowing or breathing problems
- ☐ Any disability or disabled from working

Date of last MRI? ____________
Have MRI results showed any lesions of MS? YES ☐ NO ☐

Any new lesions on the most recent MRI? YES □ NO □

Do you currently use any type of nicotine/tobacco products? YES □ NO □
If yes, type of tobacco used? Cigarettes □ Cigars □ Chew □ Pipe □ Patch/gum□

Have you ever used nicotine/tobacco in the past? YES □ NO □
Type used & date quit: ____

Any other health problems or impairments? ____________________________________

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List medications & dosages: ____

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