"LIVING WELL"—*An Integrative Approach to Wellness with MS*

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 ❑ Children ❑ Parent(s)
❑ Brothers +/or Sisters ❑ Other Relatives ❑ Friends
❑ Live Alone ❑ Other: _____

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:_____

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
- ❑ Emotional Changes (feelings of sadness, hopelessness, changes in appetite/sleep) (describe):_____

- ❑ Other (describe):_____

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:_____

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

If yes, check all that apply:

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

Hospitalizations, Operations and Injuries including broken bones (include dates):

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

Describe: _____

_____

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

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

Current Prescribed Medications:

Name	Dosage	How Often?

Over the Counter Medications, Vitamins, Herbs and Supplements:

Name	Dosage	How Often?

EXERCISE HISTORY

Do you currently exercise? ❑ Yes ❑ No

If yes, please indicate your current exercise program:

	Distance/Duration	Frequency per Week
❑ Walking	_____	_____
❑ Treadmill	_____	_____
❑ Bicycling	_____	_____
❑ Stationary Bicycle	_____	_____
❑ Swimming	_____	_____
❑ Yoga	_____	_____
❑ Tai Chi	_____	_____
❑ Feldenkrais	_____	_____
❑ Pilates	_____	_____
❑ Posture/Balance Exercises	_____	_____
❑ Stretching: ❑ Upper Body ❑ Lower Body		_____
❑ Weights: ❑ Upper Body ❑ Lower Body		_____
❑ Other: _____		

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 did you choose 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.

Please return the application via:
Fax (310) 479-4436 <u>Attention – Christian Starks</u>
or mail:
NMSS, Southern California and Nevada Chapter
5150 Goldleaf Circle, Suite 400
Los Angeles, CA 90056
<u>Attention – Christian Starks</u>