CENTRE FOR MOVEMENT DISORDERS

APPLICATION FORM: MULTIPLE SCLEROSIS

This form can be completed by the applicant, relative, friend or professional.

The application form will give the conductors an overview of your condition and how it impacts on you. Please answer as many questions as you feel able, as this will help to ensure that the initial consultation is meaningful.

If you have any concerns about some questions or feel that you are not able to answer them please leave them blank.

PERSONAL INFORMATION

Title: Miss/Ms/Mrs/Mr Name: _____

Date of birth: _____

Address:_____

_____

_____Postcode: _____

Contact Telephone Numbers:

Day: _____Evening:_____

E-mail: _____

Present/previous occupation: _____

If retired please give date of retirement: _____

MEDICAL INFORMATION

Date of diagnosis:_____

Which side of your body has been more affected? *Please circle.*

	LEFT	**RIGHT**	**BOTH**
Do you have stiffness?		YES	NO
Do you have paralysis?		YES	NO
Do you have tremor?		YES	NO
Is your vision affected?		YES	NO

Relevant medication- dosages and timings:

_____

_____

_____

Additional medical/ surgical information e.g. high blood pressure, arthritis, joint replacements, accidents.

_____

_____

_____

_____

_____

Do you experience pain? YES / NO

If you experience pain where do you feel it?

_____

_____

How much does this pain restrict your daily activity?

_____

_____

IMPACT OF YOUR CONDITION. *We appreciate that each day may be different, but to help us understand how your condition affects your life please answer the following questions as best you can.*

General questions:

1. Do you use aids to assist with moving around indoors?

YES NO

If yes, please state which aids: _____

2. Do you use aids to assist with moving around outdoors?

YES NO

If yes, please state which aids: _____

3. How much does fatigue impact on your daily life? Please indicate on the scale below (0 no impact; 10 maximum impact): *circle the appropriate number*

0 1 2 3 4 5 6 7 8 9 10

No impact Max. impact

4. What elements/ symptoms of the condition do you feel are the most disabling for you?

_____

_____

_____

The following questions relate to activities of daily living and how you feel your condition has affected you and your quality of life. Please circle the appropriate box:

Do you?	**Not at all**	**With help**	**On your own with difficulty**	**On your own easily**
Walk around outside?	0	1	2	3
Climb stairs?	0	1	2	3
Get in and out of a car?	0	1	2	3
Walk over uneven ground?	0	1	2	3
Cross roads?	0	1	2	3
Travel on public transport?	0	1	2	3
Manage to feed yourself?	0	1	2	3
Manage to make yourself a hot drink?	0	1	2	3
Take hot drinks from one room to another?	0	1	2	3
Do the washing up?	0	1	2	3
Make yourself a hot snack?	0	1	2	3
Manage your own money when you are out?	0	1	2	3
Wash small items of clothing?	0	1	2	3
Do your own housework?	0	1	2	3
Do your own shopping?	0	1	2	3
Do a full clothes wash?	0	1	2	3
Read newspapers or books?	0	1	2	3

Do you?	Not at all	With help	On your own with difficulty	On your own easily
Use the telephone?	0	1	2	3
Write letters or use a computer?	0	1	2	3
Go out socially?	0	1	2	3
Manage your own garden?	0	1	2	3
Drive a car?	0	1	2	3

The following questions are taken from an approved questionnaire for people with multiple sclerosis (MSQOL-54). We have chosen these as an appropriate tool to help us prepare for your initial consultation.

	How often during the past month…	All the time	Most of the time	A good deal of the time	Some of the time	A little of the time	None of the time
1.	Have you had difficulty concentrating and thinking?	1	2	3	4	5	6
2.	Did you have trouble keeping your attention on an activity for long?	1	2	3	4	5	6
3.	Have you had trouble with your memory?	1	2	3	4	5	6
4.	Have others, such as family members or friends, noticed that you have trouble with your memory or concentration?	1	2	3	4	5	6

	How often during the past month…	All the time	Most of the time	A good deal of the time	Some of the time	A little of the time	None of the time
5	Did you feel full of pep?	1	2	3	4	5	6
6.	Have you been a very nervous person?	1	2	3	4	5	6
7.	Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
8.	Have you felt peaceful and calm?	1	2	3	4	5	6
9.	Did you have a lot of energy?	1	2	3	4	5	6
10.	Have you felt downhearted and blue?	1	2	3	4	5	6
11.	Did you feel worn out?	1	2	3	4	5	6
12.	Have you been a happy person?	1	2	3	4	5	6
13.	Did you feel tired?	1	2	3	4	5	6
14.	Did you feel rested on waking in the morning?	1	2	3	4	5	6

Do you have problems with bladder continence?

Always Occasionally Never

Do you use a catheter? YES NO

Do you have problems with bowel continence?

Always Occasionally Never

On a scale of 0 to 100, with 100 representing full quality of life and 0 representing no quality of life, where do you feel you are at the moment?

Please put a mark on the line to indicate how you feel.

0 10 20 30 40 50 60 70 80 90 100

Could you please state where you heard about Conductive Education?

_____

If you have attended Conductive Education in the past could you please give the dates and place?

Do you belong to a local branch of the Multiple Sclerosis Society or similar organisation? YES NO

<u>Please complete</u> the last/following page giving us details of your GP and consultant and then sign and return this form to the address below.

Thank you for the time you have taken to provide all this information for us and we look forward to meeting you in the near future. Please ensure that you keep us up-to-date with any changes in your medical condition.

SIGNATURE: _____

DATE: _____

Please return this completed form to:

Mrs N Sandford, Administrator,
The National Institute of Conductive Education
Cannon Hill House,
Russell Road, Moseley,
Birmingham. B13 8RD.

Direct Telephone No: 0121 442 5564

Can we politely request that you use a STAMP with LARGE written on it.

In exceptional circumstances we may wish to contact your GP or consultant. We will NOT contact them without discussing this with you first.

Name and address of GP:

_____

_____

GP Telephone Number: _____

Name and Hospital of Consultant: _____

How frequently do you see your consultant?_____

Name of specialist nurse (if appropriate)_____

ANY OTHER RELEVANT MEDICAL INFORMATION YOU FEEL IT IS IMPORTANT FOR US TO KNOW:

_____

_____

_____

I agree that I have disclosed all relevant medical information to the conductors at the National Institute of Conductive Education, Birmingham. I understand that it is my duty to inform them immediately of any relevant changes in my condition or medication and agree to do so.
I agree that conductors may contact my GP or specialist should any further information be required. They will inform me of this and provide me with a copy if requested.

Signature: Date: