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.

* Required

1. Email *

Personal Information

2. Name *

3. Title

Mark only one oval.

- Miss
- Mrs
- Ms
- Mr
- Dr

4. Date of birth

Example: January 7, 2019

5. Address *

6. Postcode *

7. Day contact telephone number *

8. Evening contact telephone number

9. Present/previous occupation

10. If retired please give date of retirement

11. Year of diagnosis

Medical Information

12. Which side of your body has been more affected?

Mark only one oval.

- Left
- Right
- Both

13. Do you have stiffness?

Mark only one oval.

- Yes
- No

14. Do you have paralysis?

Mark only one oval.

- Yes
- No

15. Do you have tremor?

Mark only one oval.

- Yes
- No

16. Is your vision affected?

Mark only one oval.

- Yes
- No

17. Relevant medication, dosages and timings

18. Additional medical/surgical information

e.g. high blood pressure, arthritis, joint replacements, accidents

19. Do you experience pain?

Mark only one oval.

- ◯ Yes
- ◯ No

20. If you experience pain where do you feel it?

_____

21. 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.

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

Mark only one oval.

- ◯ Yes
- ◯ No

23. If yes, please state which aids

_____

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

Mark only one oval.

- ◯ Yes
- ◯ No

25. If yes, please state which aids

_____

26. How much does fatigue impact on your daily life?

Mark only one oval.

	1	2	3	4	5	6	7	8	9	10	
No impact	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	Maximum impact

27. 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.

28. Do you? *

Mark only one oval per row.

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

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.

29. How often during the past month.. *

Mark only one oval per row.

	All of 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
Have you had difficulty concentrating and thinking						
Did you have trouble keeping your attention on an activity for long						
Have you had trouble with your memory						
Have others, such as family members or friends, noticed that you have trouble with your memory or concentration						
Did you feel full of pep						
Have you been a very nervous person						
Have you felt so down in the dumps that nothing could cheer you up						
Have you felt peaceful and calm						
Did you have a lot of energy						
Have you felt downhearted and blue						
Did you feel worn out						
Have you been a happy person						
Did you feel tired						
Did you feel rested on waking in the morning						

30. Do you have problems with bladder continence? *

Mark only one oval.

- ◯ Always
- ◯ Occasionally
- ◯ Never

31. Do you use a catheter? *

Mark only one oval.

- ◯ Yes
- ◯ No

32. Do you have problems with bowel continence? *

Mark only one oval.

- ◯ Always
- ◯ Occasionally
- ◯ Never

33. Where do you feel you are at the moment? *

Mark only one oval.

	0	1	2	3	4	5	6	7	8	9	10	
No quality of life	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	Full quality of life

34. Could you please state where you heard about Conductive Education *

_____

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

_____

_____

_____

_____

_____

36. Do you belong to a local branch of the Multiple Sclerosis Society or similar organisation? *

Mark only one oval.

- Yes
- No

37. If yes, please state which

_____

Additional Details

38. Do you have access to a computer, iPad or tablet?

Mark only one oval.

- Yes
- No

39. Would you be interested in remote sessions if necessary?

Mark only one oval.

- Yes
- No

GP Details

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

40. Name of GP

_____

41. Address of GP

_____

_____

_____

_____

_____

42. GP Telephone Number

43. Name and Hospital of Consultant

44. How frequently do you see your consultant?

45. Name of specialist nurse (if appropriate)

46. Any other relevant medical information you feel it is important for us to know?

47. 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. *

Check all that apply.

- [ ] I agree

48. Signature / Type name

49. Date
(if printed)

Example: January 7, 2019

If printed, 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.

Please return this completed form to:

The Adult Department
Direct telephone line: 0121 442 5564

NICE – Centre for Movement Disorders
Cannon Hill House,
Russell Road,
Moseley,
Birmingham. B13 8RD

Can we politely request that when returning the application for to us you use a STAMP with LARGE written on it.