



Multiple Sclerosis Intake Form
For patients with previously diagnosed Multiple Sclerosis (MS)

Name: _____ DOB: _____ Date: _____

Briefly describe symptoms that lead to diagnosis of MS: _____

When did symptoms of MS start? (month/year) _____

When were you diagnosed with MS? (Month/year) _____

Please indicate how the diagnosis was made (*if you have not had a particular test, it is not necessary to have it prior to your appointment*). Please provide results of diagnostic studies (including disc with images) prior to your scheduled appointment.

- | | |
|--|--|
| <input type="checkbox"/> MRI Brain | <input type="checkbox"/> Lumbar puncture/CSF studies |
| <input type="checkbox"/> MRI Cervical/thoracic/lumbar spine. | <input type="checkbox"/> Visual evoked potential |
| <input type="checkbox"/> Electromyogram/nerve conduction studies (EMG/NCS) | <input type="checkbox"/> Ophthalmology consultation |

When and where were your most recent studies done? If never done, please write N/A.

| Study | When? | Where? |
|-----------------------------|-------|--------|
| MRI Brain | | |
| MRI Cervical spine | | |
| MRI Thoracic/lumbar spine | | |
| Lumbar puncture/CSF studies | | |
| JC virus test | | |
| Vitamin D level | | |
| Immunoglobulins | | |
| Ophthalmology consultation | | |

Please indicate what type of MS you have been diagnosed with:

- | | |
|---|---|
| <input type="checkbox"/> Clinically Isolated Syndrome | <input type="checkbox"/> Primary-progressive MS |
| <input type="checkbox"/> Relapsing-remitting MS | <input type="checkbox"/> Progressive-relapsing MS |
| <input type="checkbox"/> Secondary progressive MS | |

Please write the name and address of any neurologist you have consulted in the past:

Does anyone in your family have multiple sclerosis? If so, who? _____

Does anyone in your family have an autoimmune disease? If so, who and what disease? _____

Please indicate what MS has been like for you:

- I have attacks in which I am worse for a period of time (at least 24 hours), followed by improvement in my condition (complete or partial). In between the attacks I am stable.
- I am having attacks, but in between the attacks I am also getting progressively worse.
- My disease began with attacks but subsequently changed such that now I am getting progressively worse but no longer have discrete attacks.
- My disease began with attacks but subsequently changed such that now I have been getting progressively worse and still have occasional attacks.
- From the start, my disease has gotten steadily and progressively worse, but I have never had an attack.
- From the start, my disease has gotten steadily and progressively worse, but I have had occasional attacks.

If you have had any attack of MS, please describe them in chronological order. Attacks are new/recurrent symptoms lasting at least 24 hours in the absence of any infection/fever or other stressors.

| Month/year | Symptoms during attack | Duration of attack | Treatment with steroids | Did symptoms resolve completely? |
|------------|------------------------|--------------------|-------------------------|----------------------------------|
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| Which of the following have you received as a routine treatment for MS? | | | |
|---|--------------|--------------|---------------------|
| Medication | Date started | Date stopped | Reason for stopping |
| Avonex (interferon beta –1a) | | | |
| Betaseron (interferon beta-1b) | | | |
| Cellcept (mycophenolate mofetil) | | | |
| Copaxone (Glatiramer acetate) | | | |
| Cytosan (cyclophosphamide) | | | |
| Imuran (azathioprine) | | | |
| Kesimpta (ofatumumab) | | | |
| Leustatin (cladribine) | | | |
| Lemtrada (alemtuzumab) | | | |
| Mayzent (siponimod) | | | |
| Novantrone (mitoxantrone) | | | |
| Rebif (interferon beta-1a) | | | |
| Rituxan (rituximab) | | | |
| Sandimmune (cyclosporine) | | | |
| Tecfidera (dimethyl fumarate) | | | |
| Tysabri (natalizumab) | | | |
| Zeposia (ozanimod) | | | |
| Solumedrol (Methylprednisolone) | | | |
| Decadron (Dexamethasone) | | | |
| Prednisone | | | |
| Plasma exchange/pheresis | | | |
| Intravenous immunoglobulins (IVIg) | | | |

Are you able to work?

- Not able to work
 Part-time
 Full-time
Occupation: _____

Which of the following best describes you?

- I am able to carry out my usual daily activities without limitations.
- I have limitations but can carry out most of my usual daily activities, even if I may require some special provisions such as altered work hours or naps.
- I am able to carry out about only half of my usual daily activities even with special provisions.
- I am severely limited in my ability to carry out my usual daily activities.
- I need assistance with my self-care activities (dressing, bathing, transferring, going to the bathroom).

When you move about, what percentage (0% - 100%) of the time do you:

| | |
|---|--|
| Walk without an aid? | |
| Use a cane, single crutch, or hold onto another person? | |
| Use a walker or support on both sides? | |
| Use a wheelchair? | |

If wheelchair bound, how long have you been wheelchair bound and what caused you to be wheelchair bound?

Please indicate what symptoms you have experienced. Provide brief detail such as laterality (left/right), location (upper or lower extremities), severity, frequency etc. Please also state whether symptoms have resolved or are ongoing.

- Visual loss or double vision (not corrected with glasses/contacts): _____

- Weakness (loss of strength): _____

- Changes in sensation (tingling, etc): _____

- Incoordination: _____

- Loss of balance or trouble walking: _____

- Problems with bladder, bowel, or sexual function: _____

- Emotional changes: _____

- Little interest or pleasure in doing things: _____

- Memory loss/cognitive issues: _____

- Spasticity: _____

- Changes in speech: _____

- Electrical shock-like sensation when you bend your neck down (without general neck pain): _____

- Pain: _____

Do you experience worsening of any of your symptoms in the heat or when you are tired, sick, or stressed?

- No.
- Yes: which symptoms and under what circumstances? _____
