Date: _____
Form Completed by: _____
Relationship to Participant: _____

KU MS Achievement Center
Application

Applicant Information

□ I give permission to share my contact information with other members.

Name: _____

Birthdate:_____

Address:_____ County: _____

Home Phone:_____Cell Phone:_____

☐ You can text me. My cell phone company is:_____

Email:_____Date of MS Diagnosis: _____

Emergency Information

□ Check here if you would like your emergency contact copied on participant communications (i.e. newsletters, updates, closings, etc.).

Emergency contact:

1. Name:_____Cell Phone:_____

Work Phone:_____Home Phone:_____

Email:_____Relationship:_____

2. Name:_____Cell Phone:_____

Work Phone:_____Home Phone:_____

Email:_____Relationship:_____

Hospital preference:_____

Neurologist:_____Phone:_____

General Practice Physician: _____Phone:_____

Transportation method you would use to attend MSAC:_____

Name and Contact number: _____

Participant Name:_____

Disease Impact Information

Type of MS: Primary Progressive Secondary Progressive
Relapsing Remitting Not sure

Height:_____ Weight:_____

In general, would you say your health is excellent, good, fair or poor? _____

Are you free of communicable diseases? _____

Other medical conditions (check any that apply):

- Abnormal Bleeding
- Anxiety
- Arthritis
- Asthma
- Back Pain
- Cancer
- Depression
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Frequent Infections
- Osteoporosis
- Seizures
- Stroke
- Thyroid Disease

Please list other medical conditions:_____

_____

Do you receive any of the following:

Food stamps Medicare Medicaid

I have the following legal documents: (Please provide copies of these forms.)

- ☐ Durable Power of Attorney
- ☐ Durable Medical Power of Attorney
- ☐ Do Not Resuscitate (DNR)
- ☐ I wish to be an organ donor

Participant Name:_____

Communication

I grant permission to discuss my involvement in the program and any health related concerns or issues with the following individuals. Please check mark those you wish to have copied on participant communications (i.e. newsletters, updates, closings, etc.). Attach another sheet if needed.

☐ **Name:** _____ Phone:_____

Email: _____ Relationship:_____

☐ **Name:** _____ Phone:_____

Email: _____ Relationship:_____

Daily Living Activities

Tell us a bit about your current level of ability in the following areas.

	Perform Independently	Need some verbal guidance	Need some physical assistance	Need significant assistance
Dressing				
Eating				
Cooking/Meal Prep				
Grooming/Hygiene				
Toileting			Transfer or catheter	Hygiene assistance
Household Chores				
Transferring				

To what degree has MS impacted you in the following areas?

	No Impairment	Slightly Impaired	Very Impaired	Completely Impaired
Vision				
Communication				
Cognition				
Mobility				
Swallowing				
Hearing				

Participant Name:_____

Mobility

What mobility devices do you currently use:	At home	In public
None		
Cane, type:		
Walker, type:		
Manual wheelchair		
Power wheelchair		
Scooter		

Race and Ethnicity *We collect this information for grant purposes only and will not be used for any other purposes. You can choose not to answer if you desire.*

White Hispanic African American Asian/Pacific Islander

American Indian/Alaskan Native

Social

Current Living arrangement:

Alone With Family Assisted Living Long Term Care Center

Have you been a resident in a nursing home? Yes No

If yes, when and for how long?_____

How frequently do you see or talk to relatives?_____

How frequently do you see or talk to friends?_____

Are you involved in any church or community organizations?_____

Please list any hobbies you enjoy:_____

Do you currently work? Full Time Part Time Do Not Work

If you do not work, are you on disability? Yes No

Do you currently volunteer? Yes No

Participant Name:_____

If yes, what activities and for what organization?_____

_____

What do you hope to gain from participating in the MS Achievement Center?

_____

_____

_____

Current Medications

Medication	Dosage