Pre-Assessment Questionnaire – Multiple Sclerosis

Please complete the questionnaire on the following pages as fully as possible; the information will be kept confidential. Please include copies of any written reports from your physician, therapist explaining your physical condition and any concerns regarding your health i.e. physical stress, orthopedic problems..Etc. Also any other documentation such as discharge report from hospital or Rehabilitation centre

First name:	*Last name:*	*Date of birth:*
Name commonly used:	*Gender*: Male Female	
Address:		
Phone numbers:	*email:*	

Emergency contact name:	
Address:	
Phone numbers:	*email:*

Participant weight:	*Height:*
Diagnosis:	
Cause of injury/ First indication of problems:	
Has anyone in your family had the same diagnosis?	*Yes (please specify))* *No*

Medical Information:

Do you have/had any :

Allergies?(food, medication...etc)

Yes (please specify) No

Seizures/Epilepsy ?

Yes (give details) No

Surgeries?

Yes (please specify) No

Miscellaneous injuries ?

Yes (please specify) No

Any other medical problem ?

Yes (please specify) No

Any ortopedic problem/dislocation/contractures ?

Yes (please specify) No

Please state any physical/emotional...Etc concerns or other information what Angel N Butterflies needs to know:

Please list all your current medication and the reason you taking it:

Please describe any rehabilitation treatment that you are receiving for your condition.(e.g. physiotherapy, OT, yoga...etc)

Do you use any assistive equipment? (Wheelchair, walker, canes, braces...Etc)

Yes (please specify) No

Please list any aims you would like to work on in the Conductive Education settings:

Daily activities:

How your condition is affecting your daily life? (Describe...)

Are you able to...?	***Not at all***	***With support***	***On your own with difficulty***	***On your own easily***	***Comments***
Sit up from bed					
Turn over in bed					
Sitting on a stool					
Sit down from standing					
Stand up from sitting					
Get up from the floor					
Transferring from wheelchair to a chair					
Transferring from bed to chair					
Walk indoors					
Walk outside					
Walking on stairs					
Walk over uneven ground					
Pick up objects from floor					
Get in and out of the car					
Drive a car					
Travel on public transit					
Bath or shower					
Preparing meal					

Diagnosis: Multiple Sclerosis

Type of Multiple Sclerosis (if known): Date of diagnosis:

History since diagnosis:

Which side of your body has been more affected? Left Right Both

Please describe the symptoms of your condition!

Do you experience...?

Weakness:

Yes (please specify) No

Fatigue:

Yes (please specify) No

Stiffness:

Yes (please specify) No

Speech and breathing problems

Yes (please specify) No

Visual problems *(double vision, vision loss...etc)*

Yes (please specify) No

Disturbance and balance of gait

Yes (please specify) No

Sensory issues

Yes (please specify) No

Tremor

Yes (please specify) No

Continence problems (bladder, bowel movement problems)

Yes (please specify) No

Additional symptoms or comments:

I hereby state that the above information is true to the best of my knowledge.

Date: Signature:

Please send your form by email to: angelnbutterflies@gmail.com

Or by mail: Angel N Butterflies

981 Gulf Place Apt 1601

Ottawa, Ontario, K1K3X9

Book an appointment for the personal assessment by email or call 613 438 0865.

Thank you for your interest. We look forward working with you and helping you achieve greater independence.

Best regards