MULTIPLE SCLEROSIS

PRODUCER NAME:_____

CLIENT NAME: _____

Submit the Client Information Questionnaire with this form

1. List date of first diagnosis:_____

2. Indicate:
   Number of episodes: _____
   Date of last episode: _____

3. List all medications client is taking. (accurate name, dosage, and reason)

4. Please note current neurological status and/or symptoms.
   - ☐ Normal
   - ☐ Minimal residual impairment (please specify) _____
   - ☐ Moderate residual impairment (please specify) _____
   - ☐ Severe residual impairment (please specify) _____

5. What are client's current symptoms?

6. What therapy is client on?

7. Does client have any problems with extremities, kidneys, or bladder? If yes, give details.

8. Does client have any other health problems? (additional questionnaires may be required)

Please fax to 612-392-7644 or email to mvp@mvpservicesolutions.com