PARALYSIS—SIMILAR PHYSICAL DISABILITY

CLIENT NAME: _____
Submit the Client Information Questionnaire with this form

1. What was the cause (e.g., congenital, injury, polio)? When did it happen?

2. What parts of the body are affected?

3. Does client have limitations in walking, driving, speech or other activities?

4. Has surgery been performed or planned?

5. Has client's bowel or bladder function been affected?

6. Does the client have any other health problems? (additional questionnaires may be requested)

PRODUCER NAME:_____

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