

## MS CLIENT REGISTRATION & SELF ASSESSMENT FORM

<b>Full Name:</b>							<b>Title:</b>					
<b>Address:</b>												
<b>Town:</b>					<b>Post Code:</b>							
<b>Email:</b>												
<b>Contact Numbers:</b>	<b>Home:</b>						<b>Mobile:</b>					
<b>Date of Birth:</b>			<b>SEX</b>	FEMALE	MALE	INTERSEX	MtF FEMALE	FtM MALE				
<b>Your Household Are you currently Living with?</b>	<b>Partner</b>	<b>Family</b>	<b>On own</b>	<b>Supported accommodation</b>			<b>Other (please detail)</b>					
<b>Information About Your MS</b>												
<b>MS Diagnosis:</b>	BMS	PPMS	RRMS	SPMS	<b>Date of Diagnosis:</b>							
<b>What Symptoms are of concern (please ✓ appropriate box/es)?</b>												
<b>FATIGUE</b>						<b>SPEECH PROBLEMS</b>						
<b>POSTURE &amp; SEATING</b>						<b>SWALLOWING PROBLEMS</b>						
<b>VISION DISTURBANCE</b>						<b>SLEEP DISTURBANCE</b>						
<b>BALANCE PROBLEMS</b>						<b>POOR CIRCULATION</b>						
<b>WEAKNESS IN ARMS</b>						<b>PAIN</b>						
<b>WEAKNESS IN LEGS</b>						<b>SENSATION CHANGES</b>						
<b>BLADDER PROBLEMS</b>						<b>EMOTIONAL CHANGES</b>						
<b>BOWEL PROBLEMS</b>						<b>FOOT PROBLEMS</b>						
<b>Medical Information</b>												
<b>Medical Centre:</b>												
<b>Address:</b>												
					<b>Post Code:</b>							
<b>Main GP Seen:</b>					<b>Tele:</b>							
<b>MS Consultant</b>					<b>Clinic:</b>							
<b>Emergency Contact: (Family/Friend)</b>	<b>Name:</b>					<b>Phone:</b>						
<b>Relationship:</b>												
<b>Main Carer (if applicable)</b>	<b>Name:</b>					<b>Phone:</b>						

About You										
Do you receive a CARE package?									Please ✓ if Not Applicable:	
No:	<input type="checkbox"/>	Yes (please give details)	<input type="checkbox"/>	Self Directed Support	<input type="checkbox"/>	Direct Payments	<input type="checkbox"/>	Local Authority	<input type="checkbox"/>	Private Care
Do you provide Care for someone?										
No	<input type="checkbox"/>	Yes (please give details)	<input type="checkbox"/>							
Do you receive any other health or social care services? E.g. District Nurse, Social Work, CPN, OT										
No	<input type="checkbox"/>	Yes (please give details)	<input type="checkbox"/>							
How did you hear about us?:		GP/ Hospital		<input type="checkbox"/>	Internet Search	<input type="checkbox"/>	Friend/ Family		Other (specify)	
Are you currently		Employed			<input type="checkbox"/>	Retired		<input type="checkbox"/>	Unable to work	
		Full time		<input type="checkbox"/>	Part time		<input type="checkbox"/>	Receipt of DLA/PIP		<input type="checkbox"/>
				<input type="checkbox"/>			<input type="checkbox"/>	Receipt of Benefit		<input type="checkbox"/>

Which MSTC Services/Therapies are you interested in? <i>(Please tick appropriate box/es)</i>	Information & Advice		MS Factsheets		<input type="checkbox"/>	Benefits/Finances		<input type="checkbox"/>	Housing		<input type="checkbox"/>
			Nutrition/Diet		<input type="checkbox"/>	Support Services		<input type="checkbox"/>	Carers Support		<input type="checkbox"/>
			Self Directed Support		<input type="checkbox"/>	MS Support Grants		<input type="checkbox"/>	Assessments		<input type="checkbox"/>
	Complementary Therapies		Reflexology		<input type="checkbox"/>	Massage		<input type="checkbox"/>	Reiki		<input type="checkbox"/>
	Neurological Physiotherapy		1:1 Physio		<input type="checkbox"/>	Group Classes		<input type="checkbox"/>	Acupuncture		<input type="checkbox"/>
	Adapted Exercise		Pilates				<input type="checkbox"/>	Yoga		<input type="checkbox"/>	
	Oxygen Treatment		<input type="checkbox"/>								
Do you use a walking/mobility aid?		Yes		<input type="checkbox"/>	No		<input type="checkbox"/>	Details:		<input type="checkbox"/>	

How do you travel to the Centre?										
Car	<input type="checkbox"/>	Public Transport	<input type="checkbox"/>	Taxi	<input type="checkbox"/>	Specialist mobility taxi/bus	<input type="checkbox"/>	Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>

## MS Evaluation (MSIS-29)

<b>In the past two weeks, how much has your MS limited your ability to:</b>	<b>Not at all</b>	<b>A little</b>	<b>Moderately</b>	<b>Quite a bit</b>	<b>Extremely</b>
1. Do physically demanding tasks?	1	2	3	4	5
2. Grip things tightly (e.g. turning on taps)?	1	2	3	4	5
3. Carry things?	1	2	3	4	5

<b>In the past two weeks, how much have you been bothered by:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
4. Problems with your balance?	1	2	3	4	5
5. Difficulties moving about indoors?	1	2	3	4	5
6. Being clumsy?	1	2	3	4	5
7. Stiffness?	1	2	3	4	5
8. Heavy arms and/or legs?	1	2	3	4	5
9. Tremor of your arms or legs?	1	2	3	4	5
10. Spasms in your limbs?	1	2	3	4	5
11. Your body not doing what you want it to do?	1	2	3	4	5
12. Having to depend on others to do things for you?	1	2	3	4	5
13. Limitations in your social and leisure activities at home?	1	2	3	4	5
14. Being stuck at home more than you would like to be?	1	2	3	4	5
15. Difficulties using your hands in everyday tasks?	1	2	3	4	5
16. Having to cut down the amount of time you spent on work or other daily activities?	1	2	3	4	5
17. Problems using transport (e.g. car, bus, train, taxi, etc.)?	1	2	3	4	5
18. Taking longer to do things?	1	2	3	4	5
19. Difficulty doing things spontaneously (e.g. going out on the spur of the moment)?	1	2	3	4	5
20. Needing to go to the toilet urgently?	1	2	3	4	5
21. Feeling unwell?	1	2	3	4	5
22. Problems sleeping?	1	2	3	4	5
23. Feeling mentally fatigued?	1	2	3	4	5
24. Worries related to your MS?	1	2	3	4	5
25. Feeling anxious or tense?	1	2	3	4	5
26. Feeling irritable, impatient, or short tempered?	1	2	3	4	5
27. Problems concentrating?	1	2	3	4	5
28. Lack of confidence?	1	2	3	4	5
29. Feeling depressed?	1	2	3	4	5

**I wish to use the Oxygen Treatment Service (please tick)**

<b>Oxygen Treatment Checklist</b>	<b>No</b>	<b>Yes</b>	<b>If yes, please give details including dates.</b>
<b>Have you been on any of the following medication?</b> Doxorubicin (Adriamycin), Bleomycin, Disulfiram (Antabuse/Refusal), Cisplatinum, Mafenide Acetate (Sulfamylon), Levothyroxine, Fluoxetine.			
<b>Are you currently on any of the following medication?</b> Codeine, Hydrocodone, Ibuprofen, Oxycodone, Paracetamol, Tramadol or Zolpidem.			
a) Have you had a pneumothorax (collapsed lung)? b) Was it properly treated?			
Do you have emphysema?			
Have you ever had tuberculosis?			
Do you have Chronic Obstructive Pulmonary Disease?			
Have you ever had any other lung problems?			
Have you had any surgery in the last six months?			
a) Have you ever had a seizure? b) Was it induced by drugs or alcohol			
Do you have a cold, chest infection etc?			
Do you suffer from chronic sinusitis?			
Do you have a temperature or a fever?			
Do you have Otosclerosis ( <i>bone growth of the middle ear</i> )?			
Have you ever had a rupture of the oval or round membrane of the inner ear?			
Do you have optic neuritis?			
Do you have glaucoma?			
Do you have congenital spherocytosis (auto-hemolytic anemia- disease of the blood)?			
Do you have a pacemaker or other medical devices?			
Are you pregnant?			
Do you suffer from any long term conditions? e.g. claustrophobia, diabetes, epilepsy,			
Are you or have you ever been a smoker?			

### **Oxygen Treatment Plan (Office Use Only)**

Client Name:		Health Condition	
Introductory Session			
Date:		O2T Session details:	Pressure: <input type="text"/> Time: <input type="text"/> Booklet Received <input type="checkbox"/>
Number of Sessions to be completed:	<input type="text"/>	Protocol Number:	<input type="text"/> Start Date: <input type="text"/>
End Date:	<input type="text"/>	Follow –up/Review Date:	<input type="text"/>
<b>Treatment continuation (PTP):</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequency: Weekly: <input type="checkbox"/> Twice weekly: <input type="checkbox"/>

*MSTC does not provide medical advice, diagnose health conditions or prescribe treatments. We base a client's access to, and engagement with oxygen treatment on a client's self-declared condition/s and prescribed medications. Access to, and appropriateness of treatment is based on assessment of client self-declared information and existing evidence and protocols within the field of hyperbaric medicine.*

## Client Consent

- I confirm my willingness to participate in Oxygen Treatment and other therapies as appropriate at the MS Therapy Centre.
- I will inform MS Therapy Centre staff of any changes to my medical condition or medications.
- I am aware that the therapy may not be beneficial to me and that it is not possible to know in advance if I will benefit.
- I hereby give my consent for my General Practitioner and/or other health and social care agencies to be contacted concerning my suitability for therapies and/or to obtain any necessary information that may be relevant.
- I also consent to me being transferred by patient transfer hoist or other recognised procedures as may be required on an emergency basis, but I confirm that I am aware that the Centre's policies require me to provide for physical or other assistance under normal circumstances.
- I give my permission for the MS Therapy Centre to keep a copy of the Assessment and other records on file.
- I confirm that I have received, read and will comply with the guidance, health & safety procedures and other information included in the : ***Oxygen Treatment Guidance & Information booklet, including Fire Instructions and Health & Safety procedures, and Cancellation Policy***
- I accept that if I do not follow MS Therapy Centre Lothian staff instructions I do so at my own risk, and MS Therapy Centre Lothian will not be held liable for any accidents that occur.
- I understand that the MS Therapy Centre Lothian is not part of the NHS and is a privately managed self-help charity that employs professional staff and trained volunteers and relies on contributions from clients and supporters in order for it to continue its work.
- The MS Therapy Centre Lothian may use my email address for information and notifications regarding the Charity's business

*In accordance with the Data Protection Act 1998, all personal data supplied to MSTC Lothian (the data controller) will be held in the strictest confidence and will not be passed on to any third parties without your consent. Your personal data will only be used for the purposes of administering client services at the Centre. If you have any concerns regarding the way your personal information is stored or used by MSTC Lothian, you may contact Nancy Campbell on 0131 554 5384.*

Client Name:		Signature:	
Date:			
<b>FOR OFFICE USE ONLY</b>			
Date Received:		Additional Information & Notes:	
Date Reviewed:			
Date GP Letter Sent:			
Date GP Information Received:			
Physiotherapy Referral:			
O2T Suitability	YES	NO	Personal Therapy Plan
On behalf of MS Therapy Centre Name:			
Signature:			
Date:		SO Details:	

