Multiple Sclerosis Clinic New Patient Intake Questionnaire
(Please complete all 3 pages and bring to your appointment.)

Date _____
Name _____
Home Address_____
_____
City State Zip
Date of Birth_____

Relationship Status
☐ Single
☐ Married
☐ In A Relationship
☐ Other

Occupation_____

Primary MD _____ ***Address*** _____
Referring MD_____ ***Address*** _____

Reason for clinic visit? List the 3 most important things that you would like us to help you with during your visit. This might include questions, concerns, or symptoms that need treatment.

1. _____
2. _____
3. _____

List medical problems:
_____
_____
_____
_____

Surgeries (list type and year):
_____
_____
_____
_____

Family History:

Any Family Members With MultipleSclerosis_____
Any Family Members with Neurological Conditions _____
Any Family members with Autoimmune disorders _____

Health Habits:

Smoker: ☐ Never ☐ Current ☐ Past Alcohol: ☐ Never ☐ Current ☐ Past Drinks per Week _____

Recreational drug or Substance use: ☐ Never ☐ Current ☐ Past
If Current, Which _____

Hours of Sleep per Night _____

PT.NO

NAME

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

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Activities of Daily Living:
Because of a health or physical problem, do you have any difficulty with:

Activity	Yes	No
Doing light housework (like washing dishes, straightening up, dusting)?	☐	☐
Doing heavy housework (like scrubbing floors, washing windows)?	☐	☐
Preparing your own meals?	☐	☐
Shopping for personal items (like groceries, medicines, toiletries)?	☐	☐
Managing money (like keeping track of money, paying bills)?	☐	☐
Bathing or showering?	☐	☐
Dressing?	☐	☐
Eating?	☐	☐
Getting in or out of bed or chairs?	☐	☐
Using the toilet?	☐	☐
Walking?	☐	☐
Breathing or coughing?	☐	☐

Functional History:
Where do you live? ☐ house ☐ Apartment ☐ Other

Does anyone live with you? ☐ Live alone ☐ Family ☐ Friends ☐ Other

Are you working? ☐ Yes ☐ No If no please state reason and stop date below:

_____

Are you currently in therapy: ☐ Physical ☐ Occupational ☐ Speech therapy

Are you currently exercising ?(please list exercise routine):

_____

Adaptive Equipment: *(such as cane, wheelchair, walker, etc)***.** Please list items you currently use:

_____

Signature *(Patient or Person Authorized to Give Authorization)*	**Print Name**	**Date**

If signed by person other than patient, please define your relationship to patient:
☐ Guardian ☐ Health Care Power of Attorney ☐ Parent
☐ Spouse/Registered Domestic Partner ☐ Adult Child ☐ Other _____

I have reviewed this information with the patient and/or caregiver.

PHYSICIAN/ARNP/PA SIGNATURE	PRINT NAME	PAGER	NPI	DATE	TIME

PT.NO

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