Acupuncture Program Application

Name: _____

Address: _____

_____

Phone: _____ Email: _____ @ _____

Access & Mobility Needs (Check All That Apply)

☐ Wheelchair ☐ Walker ☐ Cane ☐ ADA Restroom ☐ Other _____

What Year Were You Diagnosed With MS? _____

What Type Of MS Do You Have?

☐ Progressive Relapsing ☐ Relapsing Remitting ☐ Primary Progressive ☐ Secondary Progress

What Are The Main Symptoms That You Would Like To Treat With Acupuncture?

☐ Changes in vision	☐ Numbness/tingling	☐ Tremors/spasm	☐ Eye pain
☐ Muscle weakness	☐ Trouble walking	☐ Fatigue	☐ Depression
☐ Dizziness/vertigo	☐ Bowel difficulty	☐ Urinary difficulty	☐ Pain
☐ Memory loss	☐ Anxiety	☐ Nausea/vomiting	☐ Headaches
☐ Insomnia	☐ Other _____		

What Are Your Current Goals For Treatment?

On A Scale Of 1 - 10, Please Rate Your Current Level Of Discomfort? (Check One)

Best	1	2	3	4	5	6	7	8	9	10	Worst
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

On A Scale Of 1 - 10, How Would You Rate Your Overall Health? (Check One)

Best	1	2	3	4	5	6	7	8	9	10	Worst
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Are You Currently Diagnosed With Any Illnesses That Are Not MS-Related? ☐ Yes ☐ No

If Yes, Please Specify:

Thank you! This information will not be shared with anyone including your practitioner.