Multiple Sclerosis Society of Portland, OR, Inc. 2901 SE 122nd Ave. Portland, OR 97236 Phone: 503.297.9544 Fax: 503.297.6264 Email: candycehayes@msoregon.org	Date Sent: Date Received: Dr's Note: Verification:	**MSSP Office USE ONLY**
LMT Preference: __ Male __ Female __ Either | **Locale:** __ Home __ Office | **Stairs:** __ Yes __ No **Area:**_____ No Application Deadline		

"Project Helping Hands"

CLIENT APPLICATION

Client Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Emergency contact & telephone: _____

1. Date diagnosed: _____ Type of MS: _____

2. Current doctor: _____ Telephone: _____

3. Do you use assistive devices (walker, wheelchair, scooter): No ☐ Yes ☐
Specify: _____

4. Do you need help to transfer from wheelchair to bed?: No ☐ Yes ☐
Comments:

5. "LMT" stands for licensed massage therapist. Whom do you prefer to be seen by?
Male ☐ Female ☐ Either ☐
Comments:

6. Are you capable of going to the therapist's office? No ☐ Yes ☐

7. When would you like to begin receiving LMT visits? _____

_____ _____
Signature Date

The cost for the service is $10.00 per visit. Financial scholarships are available. Our office will contact you when we have found a therapist LMT who meets your needs. Be sure to keep our office updated with your current address and telephone number.