

MSAA ID Number

Office Use Only

MSAA PERSONAL DATA

You are:

An Individual w/MS

A Care Partner

A Physician

Social Services Professional

Medical Professional

Friend or Relative of someone with MS

Other _____

Name _____

Address _____

City

County

State

Zip

Date of Birth _____ Female Male Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____

Fax _____ Email address _____

The return of this form enables you to apply for all MSAA programs and services and to receive a free, ongoing subscription to the MSAA quarterly magazine, *The Motivator*. If you do not wish to receive *The Motivator*, please check the box below.

I do not wish to receive the MSAA quarterly magazine, *The Motivator*.

I do not wish to receive MSAA emails.

How did you learn about MSAA?

Neurologist

Primary Care Physician

Other HealthCare Providers

Social Services Professional

Other MS organizations

MSAA Client

MSAA Activity

MSAA Publication

Motivator

Friend/Family

Pharmaceutical Company

Internet

Phone Book

Volunteer

Media

Fundraising Call

Fundraising Letter

Do not recall

If you have MS, please enter additional information on the back of this form.

For assistance in completing this form or for more information on MSAA programs and services, please contact one of our Helpline Consultants at 800-532-7667.

Important Note:

MSAA's policy is to strictly maintain the confidentiality and security of all personal and medical information. MSAA will use the personal and medical information, which has been voluntarily provided, only to assist in acquiring requested services or benefits. MSAA will not share names or other individually identifiable health information unless it is necessary to acquire a requested service or benefit.

Please return this form to:

**The Multiple Sclerosis Association of America
706 Haddonfield Road
Cherry Hill, New Jersey 08002**

800-532-7667

EMAIL ADDRESS: msaa@msaa.com

WEB SITE ADDRESS: www.msaa.com

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MSAA PERSONAL DATA continued

For individuals with MS, please complete the following:

MS Classification:	Benign Relapsing/Remitting	Secondary Progressive Progressive Relapsing	Primary Progressive Unclear diagnosis	
Year Diagnosed:	_____			
Other Conditions:	_____			
Wheelchair Use:	None	Occasional	Moderate	Always
Assistive Devices:	Cane	Crutches	Walker	Scooter
	Other: _____			

Symptom <i>(check all that trouble you)</i>	Fatigue	Loss of Memory and Attention	Depression	Headaches
	Tingling	Difficulty with Problem Solving	Balance Difficulty	Speech Difficulty
	Numbness	Bladder Problems	Coordination Loss	Swallowing Difficulty
	Burning Sensation	Bowel Problems	Leg Heaviness	Heat Sensitivity
	Pain	Vision Loss/Blur	General Weakness	Cold Sensitivity
	Muscle Spasms		Tremors	Other Symptoms
	Muscle Tightness		Dizziness/Vertigo	

Tests you've had:	MRI [Brain]	MRI [Spine]	Spinal Tap	Evoked Potentials	
MS drugs you use:	Avonex [®]	Betaseron [®]	Copaxone [®]	Novantrone [®]	Rebif [®] Tysabri [®]
	Other: _____				
Are you currently involved in a clinical trial?	Yes		No		
If yes, please list location: _____					

Ethnic Origin: (optional)	
American Indian or Alaska Native	Hispanic or Latino
Asian	Native Hawaiian or Other Pacific Islander
Black or African American	White
Chicano or Mexican American	Other (please specify): _____

Annual Income <i>(for family living in primary domicile)</i>	
Less than \$10,000	\$60,001 to \$70,000
\$10,001 to \$20,000	\$70,001 to \$80,000
\$20,001 to \$30,000	\$80,001 to \$90,000
\$30,001 to \$40,000	\$90,001 to \$100,000
\$40,001 to \$50,000	More than \$100,000
\$50,001 to \$60,000	

PLEASE LIST:

Primary Care Physician: _____ Phone: () _____

Address: _____

Neurologist: _____ Phone: () _____

Address: _____