THE BOSTER CENTER
FOR MULTIPLE SCLEROSIS

NAME_____ DOB _____

8000 RAVINES EDGE COURT | SUITE 200 | COLUMBUS, OHIO 43235
PH. 614.304.3444 | FAX 614.304.3433 | INFO@BOSTERMS.COM

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

*Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. I, _____ authorize **The Boster Center for Multiple Sclerosis** to use and disclose the
patient name
protected health information below.

EFFECTIVE TIME PERIOD

2. This authorization for release of information covers the period of healthcare from:

○ a. **all past, present, and future periods** OR ○ b. _____ _____

EXTENT OF AUTHORIZATION

3 I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of patient or personal representative | Printed name of patient or personal representative/relationship

_____
Date

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PATIENT'S DETAILS

First Name: | Last Name: | Middle Name:

Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single

Patient is: ☐ Policy Holder ☐ Resp. party

Address:

City: | State: | Zip Code:

Home Phone: | Employer: | Work Phone:

Birth Date: | Social Security no: | Driver's License no:

E-mail Address:

Receive correspondences via e-mail: ☐ Yes ☐ No

RESPONSIBLE PARTY *(TO BE COMPLETED IF OTHER THAN PATIENT)*

First Name: | Last Name: | Middle Name:

Address:

City: | State: | Zip Code:

Home Phone: | Mobile Phone: | Work Phone:

Birth Date: | Social Security no: | Driver's License no:

PRIMARY INSURANCE INFORMATION

Primary Insurance Information:

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security no: | Insured Birth Date: | Insurance Company:

Employer: | Group ID:

LEGAL NOTICE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Boster Center for Multiple Sclerosis or insurance company to release any information required to process my claims.

I, _____ have received a copy of this Document.

Full Name: | Signature: | Date:

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PRIMARY CARE PHYSICIAN

Provider Name:

Specialty:

Address:

City:

State:

Zip Code:

Phone:

Fax:

Date of last appointment:

Comments:

CIRCLE OF CARE

Please list all healthcare providers that you would like to be included in your circle of care below

Provider Name:

Specialty:

Address:

City:

State:

Zip Code:

Phone:

Fax:

Date of last appointment:

Comments:

Provider Name:

Specialty:

Address:

City:

State:

Zip Code:

Phone:

Fax:

Date of last appointment:

Comments:

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FAMILY MEDICAL HISTORY

Complete this page with information about a close relative's health history. List the name of the relative and their relationship to you.

	Name	Relationship	Age
Alcohol or drug abuse			
Allergies			
Autoimmune disease			
Birth defects			
Blood disease			
Bone and joint diseases			
Cancer			
Hearing disorder			
Diabetes or insulin resistance			
Epilepsy			
Gastrointestinal disorder			
Glandular disorder			
Heart disease (including heart attack)			
High blood pressure			
High cholesterol			
Infertility or repeat pregnancy loss			
Intellectual disabilities			
Immunodeficiency disorder			
Kidney disease			
Lung disease			
Mental disorder (such as depression)			
Migraines			
Muscular disease			
Nerve disorder			
Ocular disease			
Skin disease			
Stroke			
Sudden, unexpected death			

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FATIGUE SEVERITY SCALE (FSS)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you circle a number (1 to 7) for every question.

During the past week, I have found that: *Disagree <--------> Agree*

My motivation is lower when I am fatigued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Exercise brings on my fatigue.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
I am easily fatigued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue interferes with my physical functioning.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue causes frequent problems for me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
My fatigue prevents sustained physical functioning.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue interferes with carrying out certain duties/responsibilities.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue is among my three most disabling symptoms.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue interferes with my work, family, or social life.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

Total Score:

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your level of fatigue.
It's simple: Add all the numbers you circled to get your total score.

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HEALTH QUESTIONNAIRE

In preparation for your visit today, please fill out the following questionnaire. Please answer "yes" if you have experienced any of these symptoms since your last visit that have lasted longer than a 24-hour period. If "yes," please describe it under the comments section.

	SYMPTOM	YES	NO	COMMENT
1	DOUBLE VISION		○	
2	LOSS OF VISION / DECREASED VISION IN ONE EYE		○	
3	DIFFICULTY SPEAKING/SLURRED SPEECH		○	
4	DIFFICULTY SWALLOWING		○	
5	NUMBNESS/TINGLING		○	
6	WEAKNESS OF A LIMB		○	
7	MOTOR FATIGUE *(I CANT WALK AS FAR BECAUSE LEGS BECOME WEAK)*		○	
8	POOR COORDINATION/BALANCE		○	
9	ELECTRICAL SHOCK DOWN MY BACK INTO MY LEGS WITH NECK FLEXION		○	
10	STIFFNESS / SPASMS / CRAMPS		○	
11	DIFFICULTY WITH THINKING AND MEMORY		○	
12	FATIGUE *(POOR ENERGY LEVELS THAT INTERFERE WITH LIFE)*		○	
13	DEPRESSION *(SAD, CRYING SPELLS, IRRITABILITY)*		○	
14	MY MS SYMPTOMS INTENSIFY WHEN BODY IS OVERHEATED		○	
15	URINARY URGENCY *(I HAVE TO URINATE IMMEDIATELY!)*		○	
16	URINARY FREQUENCY *(I HAVE TO URINATE TOO OFTEN)*		○	
17	URINARY RETENTION *(IT'S HARD TO EMPTY BLADDER OR START STREAM)*		○	
18	BOWEL COMPLAINTS *(CONSTIPATION, LOSS OF CONTROL)*		○	
19	SEXUAL DYSFUNCTION		○	
20	HEADACHES		○	
21	POOR SLEEP		○	

Is there anything else you would like to share with us in preparation for today's visit?

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PATIENT HEALTH QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	ADD COLUMNS	+	+	=

10 If you checked off any problems, how difficult Not difficult at all have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all ○
- Somewhat difficult ○
- Very difficult ○
- Extremely difficult ○