

MULTIPLE SCLEROSIS

Client's Name _____

If your client has a history of MS, please answer the following:

1. Please list date of first diagnosis _____
2. Please indicate the number of episodes and date of last episode:

3. Is your client on any medications?
 yes, please give details _____
 no
4. Please note current neurologic status and/or symptoms.
 normal
 minimal residual impairment (please specify) _____
 moderate residual impairment (please specify) _____
 severe residual impairment (please specify) _____
5. Does your client smoked cigarettes in the last 12 months?
 yes
 no
6. Does your client have any other major health problems (example: heart disease, stroke, cancer, etc.)?
 yes, please give details _____
 no

Agents name:

Agents Tell #

Agent Fax #

Date Submitted:

Agents e-mail address:

PLEASE FAX TO BEST MARKETING AT 1-781 643-2775