National Multiple Sclerosis Society

Free From Falls
Participant Application

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: *Home* _____ *Work* _____ *Cell* _____

E-mail address: _____ Fax: _____

Gender: ❑ Male ❑ Female Handedness: ❑ Left ❑ Right ❑ Both

Age: _____ Date of MS diagnosis: __/__/____

Emergency Contact: _____
(name/relationship) (phone #)

SOCIAL INFORMATION

Marital status		
☐ Single (never married)	☐ Married	☐ Domestic Partner
☐ Separated	☐ Divorced	☐ Widowed
☐ Other _____		

Who lives with you at the present time?		
☐ Spouse	☐ Children	☐ Parent(s)
☐ Brothers and/or sisters	☐ Other relatives	☐ Friends
☐ Live alone	☐ Other _____	

What is your current employment status?		
☐ Employed full-time	☐ Unemployed	☐ Retired
☐ Employed part-time	☐ Unemployed due to MS	☐ Retired due to MS
☐ Employed part-time due to MS	☐ Student	☐ Other _____

MEDICAL INFORMATION

Primary Care Physician:_____

Address:_____

City: _____ State: _____ Zip: _____

Phone:_____ FAX: _____

Neurologist:_____

Address:_____

City: _____ State: _____ Zip: _____

Phone:_____ FAX: _____

The following is a list of symptoms people with MS may experience. Not everyone who has MS experiences all of these symptoms.

Please check off only the symptoms you are <u>currently</u> experiencing:		
☐ Visual changes	☐ Tremors	☐ Impaired coordination
☐ Changes in sensation	☐ Spasticity (muscle stiffness)	☐ Impaired balance
☐ Pain	☐ Muscle weakness	☐ Bladder problems
☐ Fatigue	☐ Heat sensitivity	☐ Bowel problems
☐ Dizziness	☐ Emotional changes	☐ Changes in speech/swallowing
☐ Memory or other cognitive changes		☐ Other_____

Do you currently suffer any of the following symptoms in your legs or feet?		
Numbness	☐ Yes	☐ No
Tingling	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Swelling	☐ Yes	☐ No

Have you ever been diagnosed as having any of the following conditions?	**Yes**	**No**	**If Yes, Year of Diagnosis**
Abnormal Bleeding			
Angina (chest pain)			
Arthritis			
Asthma			
Back Pain			
Cancer			
Depression			
Diabetes			
Fainting			
Heart attack			
High blood pressure			
High Cholesterol			
Irregular Heart Beats			
Osteopenia/Osteoporosis			
Seizures			
Stroke			
Thyroid disease			

Have you required emergency medical care or hospitalization in the past year?

☐ Yes ☐ No

If YES, please list when this occurred and briefly explain why.

Have you ever had any condition or suffered any injury that has affected your balance or ability to walk?

☐ Yes ☐ No

If YES, please list when this occurred and briefly explain condition or injury.

Please indicate any <u>changes</u> in your vision, strength, sensation, balance or walking in the <u>last 6 months</u>.

Do you require eyeglasses?
☐Yes ☐No

List all medications that you currently take (including all "over-the-counter" and "alternative medicines")		
Name of medication	**Dosage**	**How often?**

ACTIVITIES OF DAILY LIVING

Please indicate your ability to do each of the following (*check appropriate response*).	**Can Do**	**Can do with difficulty or with help**	**Cannot Do**
a. Take care of your personal needs, such as dressing yourself	☐	☐	☐
b. Bathe yourself, using tub or shower	☐	☐	☐
c. Climb up and down a flight of stairs (such as to a second story in a house)	☐	☐	☐
d. Walk one or two blocks outside	☐	☐	☐
e. Do light household activities such as cooking, dusting, washing dishes, sweeping	☐	☐	☐
f. Do own shopping for groceries or clothes	☐	☐	☐
g. Walk ½ mile (6 or 7 blocks)	☐	☐	☐
h. Walk 1 mile (12-14 blocks)	☐	☐	☐
i. Lift and carry 10 pounds (full bag of groceries)	☐	☐	☐
j. Lift and carry 25 pounds (medium to large suitcase)	☐	☐	☐
k. Do most heavy household chores such as scrubbing floors, vacuuming, raking leaves	☐	☐	☐
l. Do strenuous activities such as hiking, digging in the garden, moving heavy objects, bicycling, other aerobic exercise	☐	☐	☐

In a typical week, how often do you leave your house? (to run errands, go to work, go to meetings, classes, church, social functions, etc.)

☐ Less than once/week ☐ 3-4 times/week

☐ 1-2 times/week ☐ Most every day

Do you use a device for mobility?

Ankle Foot Orthosis (AFO)	☐ Always	☐ Sometimes	☐ Never
Single point cane	☐ Always	☐ Sometimes	☐ Never
Three-point cane or quad cane	☐ Always	☐ Sometimes	☐ Never
Walker	☐ Always	☐ Sometimes	☐ Never
Manual wheelchair	☐ Always	☐ Sometimes	☐ Never
Power wheelchair	☐ Always	☐ Sometimes	☐ Never
Scooter	☐ Always	☐ Sometimes	☐ Never
Other:_____	☐ Always	☐ Sometimes	☐ Never

When you go for walks (if you do) which of the following best describes your walking pace?

☐ Fairly brisk (fast pace, can walk a mile in 15-20 minutes)

☐ Average or normal (can walk a mile in 20-30 minutes)

☐ Strolling (easy pace, takes 30 minutes or more to walk a mile)

☐ Slower pace (walks slowly outdoors, 5 minutes to walk a block)

☐ Do not go for walks on a regular basis.

Do you <u>currently</u> participate in regular physical exercise?

☐ Yes ☐ No

If yes, what do you do? _____

If yes, how many days per week?

☐ One ☐ Two ☐ Three ☐ Four ☐ Five ☐ Six ☐ Seven

How many times have you fallen <u>within the past 6 months</u>? _____	
	If you have fallen in the past 6 months, please give a detailed description of the fall(s): Date_____ Location (e.g., bathroom, kitchen, outside): Reason for fall (e.g. uneven surface, going downstairs): Did you require medical treatment? ☐ Yes ☐No
	If you have fallen in the past 6 months, please give a detailed description of the fall(s): Date_____ Location (e.g., bathroom, kitchen, outside): Reason for fall (e.g. uneven surface, going downstairs): Did you require medical treatment? ☐ Yes ☐No

How concerned are you about falling?

☐1	☐2	☐3	☐4	☐5
not at all	a little	moderately	very	extremely

As a result of this concern, have you stopped doing some of the things you used to do or liked to do?

☐ Yes ☐ No

How would you describe your overall health?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Why did you choose to come to this program?

Please state one (or more) personal goal(s) that you would like to accomplish in this program.

1.

2.

3.

FREE FROM FALLS PROGRAM RELEASE AND WAIVER OF LIABILITY

For consideration of participation in the Free From Falls program to be held from _____, 20____ to _____, 20_____, I , _____, waive and release the National Multiple Sclerosis Society ("Society"), its chapters, directors, officers, administrators, representatives and executors, past and present employees, volunteers, agents, supervisors, participants, all state and local governments, assigns, all sponsors, their representatives and successors and other persons (collectively, the "Releasees"), from any and all claims, liabilities, or causes of action arising out of an injury to me and from any and all claims, liabilities, or causes of action arising from my participation or attendance in this event.

Inherent and Potential Risks
I understand that Free From Falls involves strenuous physical activity. I understand that physical activity, by its very nature, carries with it certain inherent risks. I assume all risks associated with participating in Free From Falls relating to the risk of strenuous physical activity, collisions with other participants, or falling. I acknowledge that I may incur minor injuries, major injuries, and catastrophic injuries including paralysis and death. I assume all risks from contact with other participants and volunteers, negligent or wanton acts of other participants and volunteers, any defects of conditions of floor surfaces (including uneven or wet floor surfaces), and failure of other participants and non-participants to observe any safety regulations.
I agree to dress myself appropriately as to mitigate risk of physical injury to myself including, but not limited to: wearing shoes appropriate for strenuous physical activity involved in Free From Falls; and wearing clothing that is suitable to such strenuous physical activity.

I agree that the Releasees are not responsible for any personal items or property lost or stolen before, during, or after Free From Falls.

Weapons are strictly prohibited at Society events. I agree not to bring a weapon of any kind to the program, including all Society sponsored pre- and post-program activities.

Medical Evaluation
I attest that I am medically and physically able to participate in Free From Falls. If I experience any doubt as to my ability to successfully and safely participate in and/or complete Free From Falls, I take full responsibility for consulting a physician. I attest that, if I am pregnant, disabled in any way, or have recently suffered an illness, injury, or impairment, I should have or did consult a physician prior to participating in Free From Falls.
I consent to emergency medical care and transportation in the event of injury to me as medical professionals may deem appropriate. This Release extends to any liability arising out of or in any way connected with the medical treatment and transportation provided in the event of an emergency, including, but not limited to, negligence emergency rescue operations.

Voluntary Participation
I am fully aware of the risks connected with participation in Free From Falls, whether specifically listed in this Release or not, and I voluntarily elect to participate in Free From Falls knowing that this participation involves these risks.

Assumption of Risk, Waiver of Liability, Release, and Covenant Not To Sue
In consideration for being permitted to participate in Free From Falls, I voluntarily agree for myself, my family, heirs, assigns, executors, and administrators to the following:

1. **TO ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS, OR PERSONAL INJURY, INCLUDING DEATH** that may be sustained by me, or any loss or damage to property owned by me, as a result of participating in Free From Falls.

2. **TO RELEASE, WAIVE, HOLD HARMLESS, DISCHARGE, AND COVENANT NOT TO SUE** the Releasees from any and all liability, claims, actions, demands, expenses, attorney fees, breach of contract actions, breach of statutory duty or other duty of care, warranty, strict liability actions, and causes of action whatsoever, that I might have or may acquire in the future, arising out of or related to any loss,

damage, or injury, including death, that may be sustained by me, or to any property belonging to me, while participating in Free From Falls including, but not limited to, any claim that the act or omission complained of **was in whole or in part by the negligence or carelessness of the Releasees**.

Acknowledgment and Compliance with Rules
I agree to observe and obey all rules and safety procedures that accompany Free From Falls and to abide by any decision of a program official relative to my ability to safely participate in the program. I agree to exhibit appropriate behavior at all times and to obey all laws. Society and program officials may dismiss me, without refund, should my behavior endanger the safety of or negatively affect any program, person, facility, or property of any kind.

Severability
I agree that if any portion of this Release is deemed to be invalid, the remainder of the Release will still be binding and enforceable.

Photography Release
I hereby grant full permission to the Society to use, reuse, reproduce, publish, or republish any photographs, motion pictures, recordings, or any other record of my participation in this program, including all Society sponsored pre- and post-program activities, in any medium now known or hereafter developed, alone or in conjunction with other material, without restriction as to changes or alterations, as well as to use my name, voice, likeness, and/or other indicia of identity, for editorial, educational, promotional, advertising, and commercial purposes, including without limitation in connection with the solicitation of contributions and the furtherance of the corporate objectives of the Society. Further, I relinquish all rights, title, and interest in any and all photographs, motion pictures, recordings, or other records of Free From Falls I may take or capture to the Society.

I acknowledge and represent that I have carefully read and understand all terms of this Release and Waiver of Liability.

Full Name: _____

Signature: _____ Date: _____

National
Multiple Sclerosis
Society

Consent for Release of Information

I, _____, hereby give permission for the National Multiple Sclerosis Society to release information about me to persons who will be organizing and facilitating the National MS Society's "Free From Falls" Program, and for purposes of research conducted to analyze data and outcomes of my participation in the "Free From Falls Program."

The following information may be disclosed: My application form and the information contained therein, date from pre and post assessments conducted, and information provided in the course evaluation.

Purpose of disclosure: For screening purposes, for planning the program to maximize safety and relevance to participants, and possibly research conducted.

We will not disclose diagnosis and medical information outside the realm of this program.

My signature indicates that I understand what information is to be given, to whom, and for what purpose. My signature also indicates that I have read and understood this form.

Signature: _____Date: _____

National
Multiple Sclerosis
Society

Dear Doctor,

Your patient would like to participate in **Free From Falls: A National Multiple Sclerosis Society Comprehensive Fall Prevention Program.** This is an eight-week program that consists of an educational component about fall risk and strategies to minimize falls and an exercise component designed to improve posture, balance and endurance.

Your patient will need **medical clearance** from you to participate in the program since a component of the program is exercise. Please complete the form below and return it by fax or mail to the National MS Society by _____ (date). Patient authorization for release of information is below. Please contact _____ at _____ if you have any questions about our program.

Sincerely,

_____

TO BE COMPLETED BY PARTICIPANT

I, _____, _____, _____,
(Print Participant's Name) (Date of Birth) (Phone Number)

authorize my doctor to release the following requested information to the NMSS for the purpose of participating in the **Free From Falls** program.

_____ _____
Signature of Participant Date

TO BE COMPLETED BY PHYSICIAN

My patient does have multiple sclerosis and may participate in the **Free From Falls** supervised program at the level of activity he/she can tolerate.

Activities Limitations: ☐ No limitations ☐ Yes (please list): _____

_____ _____
Physician's Name (Please print) Phone Number

_____ _____
Physician's Signature Date

Please complete and FAX to _____

Free From Falls Consent Form

The **Free From Falls** program was developed to help people with MS minimize their risk of falling. The program consists of instruction about why people with MS are at a high risk of falling, tips and strategies to employ to cut down on risk and an exercise program designed to improve strength, balance and mobility.

WHAT WILL I BE ASKED TO DO?

Participants will be asked to complete surveys regarding their falls experience and their opinions about the **Free From Falls** program as well as participate in pre- and post-assessments of balance and mobility. These questions and assessments are voluntary and confidential. Your data will be used for summative reports, analyses and potential publications in which your name and any identifiers will be removed.

WHY IS THIS BEING DONE?

We are collecting this information from participants to better understand the impact of **Free From Falls** and make adjustments that might be needed to improve the program. We will use this data to help us better understand what strategies and interventions are most effective in helping people with MS minimize falls.

WHAT PROCEDURES WILL BE INVOLVED IN THIS PROCESS?

You will complete an application before the program. A falls survey and assessments of function and balance will be conducted before and immediately after the program by a health care professional who will be facilitating the exercise portion of the class. In addition, you will be asked to complete a program evaluation and will receive an email with a survey link or a mailed survey 6 months after the program ends.

WHAT ARE THE POTENTIAL RISKS AND DISCOMFORTS?

The assessments may be challenging for you to do or may demonstrate your problems with balance with mobility. Your participation in this program is strictly voluntary.

If you have any problems or questions contact ……..

Your signatures acknowledge that you have read the information stated and willingly sign this consent form. **I hereby consent to the use of my application data, evaluation information and balance assessment results in the aggregate (ensuring that all identifiable information has been removed) for analysis, publications, and future research studies conducted by the National MS Society.**

_____	_____	_____
Full Name (Please Print)	Signature	Date

Email address:_____