



CLIENT PROGRAM QUESTIONNAIRE

Name: _____

1. What programs are you interested in starting? (Check all that apply)

_____ Exercise Therapy

_____ Massage/Reflexology

Do you have any special needs or restrictions? If so, please describe:

2. Are you currently using mobility aids? (Check all that apply)

_____ Cane

_____ Crutches

_____ Walker

_____ Scooter

_____ Wheelchair

3. Occasionally, ACT for MS needs some helping hands at the office with various tasks and special events. Would you like to volunteer your time? If yes, how would you like to help?

_____ Mailings _____ Addressing Envelopes _____ Telephoning _____ Newsletter

_____ Speaking _____ Computer _____ Hosting/Helping at Fundraisers

Other _____

What is the best time for you?

_____ Morning

_____ Afternoon

_____ Evening

_____ Weekdays

_____ Weekends

4. Comments/Suggestions:
