



**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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_