

Name, first name: _____
 Birth date: _____

Source: _____


CLINICAL ASSESSMENT


Date of exam: Day Month Year


- Concurrent relapse Functional participation
 Pseudo-exacerbation

Scales

Ambulation —————

Able to run: _____ No / Yes 

Walking distance without rest: _____ Unlimited
 If limited, specify: > 500 / 100-500 / 20-100 / < 20 m 

Assistance required: _____ Unilateral / Bilateral / 
 Wheelchair / Motorized wheelchair

EGS (EDMUS Grading Scale) _____

EDSS (Kurtzke) _____

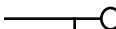

Kurtzke functional systems —————

Pyramidal	_____	Brainstem	_____
Cerebellar	_____ <input type="checkbox"/>	Visual	_____ <input type="checkbox"/>
Sensory	_____	Mental	_____
Sphincter	_____	Other	_____

MSFC scales —————

Timed 25 feet-walk	(test 1 / test 2)	_____	_____
9-HPT, dominant hand	(test 1 / test 2)	_____	_____
9-HPT, other hand	(test 1 / test 2)	_____	_____
PASAT	(3 sec / 2 sec)	_____	_____

Symptoms & signs

<input type="checkbox"/> Motor	<input type="checkbox"/> <i>Walking difficulties</i>	<input type="checkbox"/> Falls	<input type="checkbox"/> Weakness
	<input type="checkbox"/> <i>Lower extremity motor</i>	<input type="checkbox"/> Spasticity	<input type="checkbox"/> Clumsiness
	<input type="checkbox"/> <i>Upper extremity motor</i>		<input type="checkbox"/> Tremor
<input type="checkbox"/> Sensory		<input type="checkbox"/> Lhermitte sign	<input type="checkbox"/> Paresthesia
		<input type="checkbox"/> Pain	<input type="checkbox"/> Dysesthesia
<input type="checkbox"/> Sphincter	<input type="checkbox"/> <i>Bladder/bowel dysfunction</i>		
	<input type="checkbox"/> <i>Sexual dysfunction</i>		
<input type="checkbox"/> Brainstem	<input type="checkbox"/> <i>Oculomotor</i>	<input type="checkbox"/> Double vision	<input type="checkbox"/> Internuclear ophthalmoplegy
		<input type="checkbox"/> Oscillopsia	<input type="checkbox"/> Ocular nerve palsy
			<input type="checkbox"/> Gaze paresis
	<input type="checkbox"/> <i>Vestibular / Cochlear</i>	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Nystagmus
		<input type="checkbox"/> Hypoacusia	
	<input type="checkbox"/> <i>Facial motor</i>	<input type="checkbox"/> Facial palsy	<input type="checkbox"/> Myokymia
		<input type="checkbox"/> Hemispasm	
	<input type="checkbox"/> <i>Facial sensory</i>	<input type="checkbox"/> V paresthesia	<input type="checkbox"/> V hypoesthesia
		<input type="checkbox"/> V neuralgia	<input type="checkbox"/> Atypical pain
	<input type="checkbox"/> <i>Bulbar impairment</i>	<input type="checkbox"/> Speech impairment	<input type="checkbox"/> Swallowing impairment
<input type="checkbox"/> Optic neuritis		<input type="checkbox"/> Loss of visual acuity	<input type="checkbox"/> Dyschromatopsia
		<input type="checkbox"/> Ocular pain	
<input type="checkbox"/> Mental deterioration			
<input type="checkbox"/> Psychiatric symptoms	<input type="checkbox"/> Mood alteration		Depression
	<input type="checkbox"/> Delusions		Euphoria
	<input type="checkbox"/> Hallucinations		
<input type="checkbox"/> Other	<input type="checkbox"/> Uhthoff sign	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Amyotrophia
	<input type="checkbox"/> At heat	<input type="checkbox"/> Headache	<input type="checkbox"/> Extrapyrarnidal
	<input type="checkbox"/> At effort	<input type="checkbox"/> Horner	<input type="checkbox"/> Aphasia
	<input type="checkbox"/> Paroxysmal symptoms	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Lobar cerebral syndromes
	<input type="checkbox"/> Tonic spasm		<input type="checkbox"/> Other
	<input type="checkbox"/> Other		

COMMENTS