

**MS Symptom and Function Questionnaire**

This questionnaire is designed to help identify, clarify, and articulate your specific experiences with MS in your day-to-day life.

Applications for benefits (such as Canada Pension Plan Disability) require detailed explanations about symptoms and how the symptoms impact your functions and daily life. The MS Society recommends completing this questionnaire prior to filling out any application. This will help you to be clear about all your symptoms which will greatly increase the chance of a successful application.

This questionnaire can be used for:

* Preparing for Canada Pension Plan - Disability applications
* Preparing for Quebec Pension Plan - Disability applications
* Preparing for long-term disability applications
* Preparing for provincial benefit applications
* Preparing for Disability Tax Credit applications
* Sharing with doctors and specialists to clarify symptoms and be concise during short appointments
* Personal tracking of symptoms

We recommend that you have a trusted family member or friend help you complete the questionnaire or have them review it once it is done. Do your best not to minimize your symptoms – it is important to be honest and realistic when applying for benefits.

The questionnaire takes approximately 25-40 minutes to fill out.

If you have concerns, questions, or require support, please reach out to our MS Navigators. They are available 9-5 and can be reached at 1-844-859-6789 and at [msnavigators@mssociety.ca](mailto:msnavigators@mssociety.ca).

**This questionnaire is divided into two sections:**

**Part 1: Symptoms Part 2: Functions**

Symptoms refer to the difficulties you experience as a direct result of your MS (loss of balance, lack of coordination, loss of sensation, etc.)

Functions refer to the activities that are impacted by your symptoms.

Example: Loss of balance (symptom) *causes* difficulty walking (function).

In each of these sections (*Part 1: Symptoms* and *Part 2: Functions*) you will be asked similarly structured questions. While this may seem repetitive, it is important that you complete each section to the best of your ability to ensure you are identifying key details that will be helpful for successful benefit applications.

**Part 1. Symptoms**

**1. Please check all the symptoms of MS that you experience:**

Please note that the symptoms listed are comprehensive and most people will only experience certain ones. For a description of the symptoms below, please visit [mssociety.ca/about-ms/symptoms](https://mssociety.ca/about-ms/symptoms).

balance difficulties / dizziness

bladder dysfunction

bowel problems

confusion or memory troubles

depression

dry mouth

emotions which seem out of place

electric shock sensation

eye inflammation or optic neuritis

fatigue and fatigability

heat intolerance

hormonal influences

mood swings

numbness or tingling

pain

poor coordination

sleep disruption

spasms

spasticity

speaking difficulties

sudden onset of neurological symptoms

swallowing difficulties

tremors

useless hand syndrome

weakness

**2. When thinking of the symptoms which are the MOST troubling for you or the most disruptive of your day-to-day life, which symptoms would you identify?**

balance difficulties / dizziness

bladder dysfunction

bowel problems

confusion or memory troubles

depression

dry mouth

emotions which seem out of place

electric shock sensation

eye inflammation or optic neuritis

fatigue and fatigability

heat intolerance

hormonal influences

mood swings

numbness or tingling

pain

poor coordination

sleep disruption

spasms

spasticity

speaking difficulties

sudden onset of neurological symptoms

swallowing difficulties

tremors

useless hand syndrome

weakness

other (please specify)

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**3. Over time, have your symptoms been staying the same or getting worse?**

staying the same

getting worse

I’m not sure

**4. Does your experience of symptoms change over the course of a day?**

yes

no

I’m not sure

**5. At what times are your symptoms at their worst?**

in the morning

in the afternoon

in the evening

before periods of rest

after periods of rest

changes in my symptoms are unpredictable / do not seem to occur at specific times

other (please specify)

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**6. How often do you experience symptoms?**

daily

several times per week

once or twice per week

a few times per month

a few times per year

rarely

other (please specify)

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**7. How often do you experience bad days with your worst symptoms?**

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| --- | --- | --- | --- | --- | --- | --- |
| **Symptom** | Daily | Several times per week | Once or twice per week | A few times per month | A few times per year | Rarely |
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**8. In considering your MS, how bad is each symptom on your worst day?**

Rate the severity of the symptom on your worst day based on a scale from 1-10, **with 10 being the worst you can imagine**.

(If you do not experience some of the symptoms listed, leave the box blank).

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| --- | --- |
| **Symptom** | **Rating from 1-10 (10 being the worst)** |
| balance difficulties / dizziness |  |
| bladder dysfunction |  |
| bowel problems |  |
| confusion or memory troubles |  |
| depression |  |
| dry mouth |  |
| emotions which seem out of place |  |
| electric shock sensation |  |
| eye inflammation or optic neuritis |  |
| fatigue and fatigability |  |
| heat intolerance |  |
| mood swings |  |
| numbness or tingling |  |
| hormonal influences |  |
| pain |  |
| poor coordination |  |
| sleep disruption |  |
| spasms |  |
| spasticity |  |
| speaking difficulties |  |
| sudden onset of neurological symptoms |  |
| swallowing difficulties |  |
| tremors |  |
| useless hand syndrome |  |
| weakness |  |

**Part 2: Functions**

**9. Please check all the activities that you have had to stop or change due to your multiple sclerosis.**

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| --- | --- |
| **Function** | **Stop/Change (include details on the change where possible)** |
| reading |  |
| socializing |  |
| driving |  |
| watching TV |  |
| walking |  |
| sports |  |
| housework |  |
| other (please specify) |  |

**Note: from this point on, "functioning" refers to your ability to perform the functions listed below.**

**10. Please check all the functioning difficulties you experience due to your MS:**

sitting and/or standing

walking

lifting and/or carrying

reaching

bending

personal needs (eating, washing, dressing, etc.)

bowel and bladder

household maintenance (cooking, cleaning, shopping, etc.)

seeing and/or hearing

speaking

remembering

concentrating

sleeping

breathing

using public transportation

driving a car

**11. When thinking of the functions from the list below, which are the most troubling for you or the most disruptive of your day-to-day life?**

sitting and/or standing

walking

lifting and/or carrying

reaching

bending

personal needs (eating, washing, dressing, etc.)

bowel and bladder

household maintenance (cooking, cleaning, shopping, etc.)

seeing and/or hearing

speaking

remembering

concentrating

sleeping

breathing

using public transportation

driving a car

other (please specify)

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**12. Over time, has your ability to function been staying the same or getting worse?**

staying the same

getting worse

I’m not sure

**13. Does your ability to function change over the course of a day?**

yes

no

I’m not sure

**14. At what time is your ability to function at its worst?**

in the morning

in the afternoon

in the evening

before periods of rest

after periods of rest

changes in my symptoms seem unpredictable / do not seem to occur at specific times

other (please specify)

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**15. How often do you experience difficulty functioning?**

daily

several times per week

once or twice per week

a few times per month

a few times per year

rarely

other (please specify)

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**16. How often do you experience bad days with your most difficult functions?**

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| --- | --- | --- | --- | --- | --- | --- |
| **Function** | Daily | Several times per week | Once or twice per week | A few times per month | A few times per year | Rarely |
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**17. In considering your MS, how bad is each function on your worst day?**

Rate the severity on your worst day based on a scale from 1-10, **with 10 being the worst you can imagine**.

(If you do not experience some of the symptoms listed, leave the box blank).

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| --- | --- |
| **Function** | **Rating from 1-10 (10 being the worst)** |
| sitting and/or standing |  |
| walking |  |
| lifting and/or carrying |  |
| reaching |  |
| bending |  |
| personal needs (eating, washing, dressing, etc.) |  |
| bowel and bladder |  |
| household maintenance (cooking, cleaning, shopping, etc.) |  |
| seeing and/or hearing |  |
| speaking |  |
| remembering |  |
| Concentrating |  |
| Sleeping |  |
| breathing |  |
| using public transportation |  |
| driving a car |  |

**18. In addition to MS and its symptoms, do you have any other health-related illnesses, conditions or impairments?**

yes

no

**19. Please list and describe your other health-related conditions or impairments. (Please include ALL other conditions, regardless of whether they are disabling or otherwise related to your MS).**

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Now that you have completed this questionnaire, you have created a thorough summary of important information that will help you when applying for benefits.  Use it as a reference tool when asked to describe symptoms, functions and limitations asked on application forms.  It will save you time in the long run, as you will be able to quickly identify relevant information rather than having to come up with new answers each time.   If you have additional questions, please contact our MS Navigators, as described in the introduction.