**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. MS Canada 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 to assist anyone in Canada from 8am to 8pm ET, Monday to Friday and can be reached at 1-844-859-6789 and at [msnavigators@mscanada.ca](mailto:msnavigators@mscanada.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:**

Below is a list of the most common MS symptoms. This is not a comprehensive list; additional symptoms can be listed in “other.” For a description of the symptoms below, please visit <https://mscanada.ca/intro-to-ms/ms-symptoms>.

mood changes (depression, anxiety)

cognitive change (changes in how we think, remember, communicate & learn)

balance difficulties / dizziness

bladder or bowel problems

trigeminal neuralgia (electric shock sensation in face)

vision problems (loss of vision, double vision)

fatigue

heat intolerance

numbness or tingling

pain

poor coordination

sleep disruption

spasticity (spasms or stiffness)

speech or swallowing difficulties

tremors

weakness

other (please specify)

|  |
| --- |
| Click or tap here to enter text. |

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

mood changes (depression, anxiety)

cognitive change (changes in how we think, remember, communicate & learn)

balance difficulties / dizziness

bladder or bowel problems

trigeminal neuralgia (electric shock sensation in face)

vision problems (loss of vision, double vision)

fatigue

heat intolerance

numbness or tingling

pain

poor coordination

sleep disruption

spasticity (spasms or stiffness)

speech or swallowing difficulties

tremors

weakness

other (please specify)

|  |
| --- |
| Click or tap here to enter text. |

**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)

|  |
| --- |
| Click or tap here to enter text. |

**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)

|  |
| --- |
| Click or tap here to enter text. |

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Symptom** | **Daily** | **Several times per week** | **Once or twice per week** | **A few times per month** | **A few times per year** | **Rarely** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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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).

|  |  |
| --- | --- |
| **Symptom** | **Rating from 1-10 (10 being the worst)** |
| mood changes (depression, anxiety) | Click or tap here to enter text. |
| cognitive changes (changes in how we think, remember, communicate & learn) | Click or tap here to enter text. |
| balance difficulties / dizziness | Click or tap here to enter text. |
| bladder or bowel problems | Click or tap here to enter text. |
| trigeminal neuralgia (electric shock sensation in face) | Click or tap here to enter text. |
| vision problems (loss of vision, double vision) | Click or tap here to enter text. |
| Fatigue | Click or tap here to enter text. |
| heat intolerance | Click or tap here to enter text. |
| numbness or tingling | Click or tap here to enter text. |
| Pain | Click or tap here to enter text. |
| poor coordination | Click or tap here to enter text. |
| sleep disruption | Click or tap here to enter text. |
| spasticity (spasms or stiffness) | Click or tap here to enter text. |
| speech or swallowing difficulties | Click or tap here to enter text. |
| Tremors | Click or tap here to enter text. |
| Weakness | Click or tap here to enter text. |
| other (please specify)  Click or tap here to enter text. | Click or tap here to enter text. |

**Part 2: Functions**

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

|  |  |
| --- | --- |
| **Function** | **Stop/Change (include details on the change where possible)** |
| reading | Click or tap here to enter text. |
| socializing | Click or tap here to enter text. |
| driving | Click or tap here to enter text. |
| watching TV | Click or tap here to enter text. |
| walking | Click or tap here to enter text. |
| sports | Click or tap here to enter text. |
| housework | Click or tap here to enter text. |
| other (please specify) | Click or tap here to enter text. |

**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

pushing and/or pulling

reaching

bending

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

toileting (bladder and bowel)

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

pushing and/or pulling

reaching

bending

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

toileting (bladder and bowel)

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

seeing and/or hearing

speaking

remembering

concentrating

sleeping

breathing

using public transportation

driving a car

other (please specify)

|  |
| --- |
| Click or tap here to enter text. |

**12. Over time, has your ability to function stayed the same, or worsened?**

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)

|  |
| --- |
| Click or tap here to enter text. |

**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)

|  |
| --- |
| Click or tap here to enter text. |

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Function** | **Daily** | **Several times per week** | **Once or twice per week** | **A few times per month** | **A few times per year** | **Rarely** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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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).

|  |  |
| --- | --- |
| **Function** | **Rating from 1-10 (10 being the worst)** |
| sitting and/or standing | Click or tap here to enter text. |
| walking | Click or tap here to enter text. |
| lifting and/or carrying | Click or tap here to enter text. |
| pushing and/or pulling | Click or tap here to enter text. |
| reaching | Click or tap here to enter text. |
| bending | Click or tap here to enter text. |
| personal needs (eating, washing, dressing, etc.) | Click or tap here to enter text. |
| Toileting (bladder and bowel) | Click or tap here to enter text. |
| household maintenance (cooking, cleaning, shopping, etc.) | Click or tap here to enter text. |
| seeing and/or hearing | Click or tap here to enter text. |
| speaking | Click or tap here to enter text. |
| remembering | Click or tap here to enter text. |
| concentrating | Click or tap here to enter text. |
| sleeping | Click or tap here to enter text. |
| breathing | Click or tap here to enter text. |
| using public transportation | Click or tap here to enter text. |
| driving a car | Click or tap here to enter text. |

**18. In addition to MS, do you have any other health conditions?**

yes

no

**19. Please list and describe ALL other health conditions.**

|  |
| --- |
| Click or tap here to enter text. |

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.

If you have additional questions, please contact our MS Navigators. They are available to assist anyone in Canada from 8am to 8pm ET, Monday to Friday and can be reached at 1-844-859-6789 and at [msnavigators@mscanada.ca](mailto:msnavigators@mscanada.ca).