A 52-year-old left-handed Cuban female with past medical history significant for multiple strokes beginning at the age of 36, presented to our acute rehabilitation hospital with significant deficits in mobility, balance, range of motion, and strength secondary to residual effects of a stroke suffered seven months ago. During her hospitalization, she was diagnosed with a high likelihood of multiple sclerosis. Although she improved functionally throughout her stay, she did experience a transient episode of blurry vision and lower extremity weakness during a therapy session. This is a retrospective look at the acute care of a patient with repeated cerebral infarcts and multiple sclerosis. She presented to our acute rehabilitation hospital with significant deficits in mobility, balance, range of motion, and strength secondary to residual effects of a stroke suffered seven months ago. During her hospitalization, she was diagnosed with a high likelihood of multiple sclerosis. Although she improved functionally throughout her stay, she did experience a transient episode of blurry vision and lower extremity weakness during a therapy session. This is a retrospective look at the management of a patient presenting with both multiple sclerosis and stroke. Much like how the management of a patient with hypertension is altered if they subsequently develop diabetes, a patient with MS who suffers a stroke will require a uniquely tailored approach to their rehabilitation. Exercise Intensity: Doring et al, described moderate exercise intensity as a target Borg scale between 11-14, a level of optimal outcome in MS patients, without much concern for complication. Research has shown the potential for increased susceptibility to common infectious diseases like upper respiratory tract infections with vigorous, as opposed to moderate exercise intensities. Current recommendations for moderate exercise in MS patients may lie in contrast to current studies of stroke rehabilitation as it has been shown that functional improvements at three months with unassisted walking occurred with earlier and more intensive mobilization after stroke (Cumming et al., 2011). However, the term intensive was never defined. This ambiguity permeates through a number of research articles and, in fact, the Borg Scale itself has been questioned as to its validity in a study of subacute stroke patients at high intensity exercise levels when reported perceived exertion scores were compared to VO2 peak levels (Sage et al, 2013). Moreover, exercise intensities in strokes are have been traditionally quantified through metabolic equivalents. In our literature review, we were unable to find an appropriate metabolic equivalent scale for optimal training in a multiple sclerosis patient. It is, therefore, important that more research be done in order to standardize an exercise intensity scale that could be applied to multiple conditions as a base of comparison, and to further outline the appropriate levels of exercise intensity for optimal outcome in stroke, MS, and combined stroke and MS patients. Therefore, further research needs to be done to be able to recommend their use in this population.