Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ HR# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please Circle One: Male Female Please Circle One: Single Married Widowed Divorced Spouses Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ N/A
Who can we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name(s) and Age(s) of your children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Emergency Contact Name & Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you received chiropractic care in the past? 🗌 YES 🗌 NO (from whom?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Please note any significant family medical history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE GIVE YOUR INSURANCE CARD AND DRIVER’S LICENSE TO THE FRONT DESK**

Please Select Which is True for You: 🗌 Self Pay 🗌 Insured (Record the Following Insurance Information)

Primary Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY OF COMPLAINT**
Please identify the condition(s) that brought you to this office or current condition: Primary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Third: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fourth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**

**Primary** or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Second** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Third** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Fourth** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ When is the problem at its worst? ⭘ AM ⭘ PM ⭘ mid-day ⭘ late PM

How long does it last? 🗌It is constant **OR** 🗌I experience it on & off during the day **OR** 🗌It comes & goes throughout the week
How did the injury happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Condition(s) ever been treated by anyone in the past? ⭘ No ⭘ Yes **If yes,** when? \_\_\_\_\_\_\_ by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
How long were you under care? \_\_\_\_\_\_\_\_\_\_\_\_ What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE MARK** the areas on the body diagram with the following **letters** to describe your symptoms:

 **R = R**adiating **B** **= B**urning **D =** **D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

What relieves your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your symptoms feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY**

Please check the corresponding boxes for each symptoms or condition you have experienced – including both past and present.

Past
Present

Past
Present

Past
Present

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 🗌 | 🗌 | Acid Reflux/Heart Burn | 🗌 | 🗌 | Itching |  |  | **SHOULDERS ( L / R )** |
| 🗌 | 🗌 | ADD/ADHD | 🗌 | 🗌 | Kidney Problems | 🗌 | 🗌 | Shoulder Tightness |
| 🗌 | 🗌 | Allergies | 🗌 | 🗌 | Liver Problems | 🗌 | 🗌 | Shoulder Pain |
| 🗌 | 🗌 | Anemia | 🗌 | 🗌 | Loss of Balance | 🗌 | 🗌 | Pain in Shoulder Joint |
| 🗌 | 🗌 | Anxiety | 🗌 | 🗌 | Loss of Hearing | 🗌 | 🗌 | Pain Across Shoulders |
| 🗌 | 🗌 | Arthritis / Joint Pain | 🗌 | 🗌 | Loss of Memory | 🗌 | 🗌 | Can’t Raise Arms |
| 🗌 | 🗌 | Asthma | 🗌 | 🗌 | Loss of Smell | 🗌 | 🗌 | Upper-Back Pain |
| 🗌 | 🗌 | Athletic Injuries | 🗌 | 🗌 | Loss of Taste |  |  |  |
| 🗌 | 🗌 | Autism Spectrum | 🗌 | 🗌 | Low Blood Pressure |  |  | **ARMS/HANDS ( L / R )** |
| 🗌 | 🗌 | Auto Accident | 🗌 | 🗌 | Lung/Respiratory Problem | 🗌 | 🗌 | Numbness in Arms |
| 🗌 | 🗌 | Autoimmune Problems | 🗌 | 🗌 | Menstrual Problems | 🗌 | 🗌 | Numbness in Hands |
| 🗌 | 🗌 | Bladder Problems | 🗌 | 🗌 | Nausea | 🗌 | 🗌 | Pins/Needles in Arms |
| 🗌 | 🗌 | Blurred Vision | 🗌 | 🗌 | Nosebleeds | 🗌 | 🗌 | Pins/Needles in Hands |
| 🗌 | 🗌 | Bowel Changes | 🗌 | 🗌 | Pancreas Problems | 🗌 | 🗌 | Pain in Upper Arm |
| 🗌 | 🗌 | Bruise Easily | 🗌 | 🗌 | Persistent Cough | 🗌 | 🗌 | Pain in Elbow |
| 🗌 | 🗌 | Cancer | 🗌 | 🗌 | Poor Circulation | 🗌 | 🗌 | Pain in Wrist |
| 🗌 | 🗌 | Carpal Tunnel | 🗌 | 🗌 | Poor Posture | 🗌 | 🗌 | Pain in Hand |
| 🗌 | 🗌 | Changes in Moles | 🗌 | 🗌 | Prostate Problems | 🗌 | 🗌 | Pain in Fingers |
| 🗌 | 🗌 | Chest Pain | 🗌 | 🗌 | Rapid Weight Gain | 🗌 | 🗌 | Weakness of Hand |
| 🗌 | 🗌 | Chills | 🗌 | 🗌 | Rapid Weight Loss | 🗌 | 🗌 | Cold Hands |
| 🗌 | 🗌 | Chronic Fatigue | 🗌 | 🗌 | Rash |  |  |  |
| 🗌 | 🗌 | Chronic Pain | 🗌 | 🗌 | Reproductive Problems |  |  | **MIDBACK ( L / R )** |
| 🗌 | 🗌 | Constipation | 🗌 | 🗌 | Restless Sleep | 🗌 | 🗌 | Mid-Back Pain |
| 🗌 | 🗌 | Depression | 🗌 | 🗌 | Ringing in Ears | 🗌 | 🗌 | Mid-Back Stiffness |
| 🗌 | 🗌 | Diabetes | 🗌 | 🗌 | Sciatica | 🗌 | 🗌 | Pain Between Shoulder Blades |
| 🗌 | 🗌 | Difficulty Breathing | 🗌 | 🗌 | Scoliosis | 🗌 | 🗌 | Pain from Front to Back |
| 🗌 | 🗌 | Digestive Problems | 🗌 | 🗌 | Sensitive to Light | 🗌 | 🗌 | Muscle Spasms in Mid-Back |
| 🗌 | 🗌 | Disc Problems | 🗌 | 🗌 | Shallow Breathing | 🗌 | 🗌 | Pain Moving into Ribs |
| 🗌 | 🗌 | Dizziness | 🗌 | 🗌 | Shortness of Breath |  |  |  |
| 🗌 | 🗌 | Ear Pain | 🗌 | 🗌 | Seizures/Epilepsy |  |  | **LOW BACK / HIPS ( L / R )** |
| 🗌 | 🗌 | Facial Pain | 🗌 | 🗌 | Sinus Problems | 🗌 | 🗌 | Low Back Pain |
| 🗌 | 🗌 | Fainting | 🗌 | 🗌 | Skin Problems | 🗌 | 🗌 | Low Back Stiffness |
| 🗌 | 🗌 | Fibromyalgia | 🗌 | 🗌 | Sleeping Problems | 🗌 | 🗌 | Low Back Weakness |
| 🗌 | 🗌 | Gallbladder Problems | 🗌 | 🗌 | Sports Injury | 🗌 | 🗌 | Back Feels “Out of Place” |
| 🗌 | 🗌 | Headaches/Migraines | 🗌 | 🗌 | Stomach Problems | 🗌 | 🗌 | Muscle Spasms |
| 🗌 | 🗌 | Hearing Problems | 🗌 | 🗌 | Stroke | 🗌 | 🗌 | Hip Pain |
| 🗌 | 🗌 | Hemorrhoids | 🗌 | 🗌 | Stress | 🗌 | 🗌 | Pain in Buttocks |
| 🗌 | 🗌 | Hernia | 🗌 | 🗌 | Swollen Ankles |  |  |  |
| 🗌 | 🗌 | High Blood Pressure | 🗌 | 🗌 | Swollen Joints |  |  | **KNEES/LEGS/FEET ( L / R )** |
| 🗌 | 🗌 | Hives | 🗌 | 🗌 | Thyroid Problems | 🗌 | 🗌 | Pain Down Leg |
| 🗌 | 🗌 | Indigestion | 🗌 | 🗌 | TMJ (Jaw Pain) | 🗌 | 🗌 | Knee Pain |
| 🗌 | 🗌 | Inflammation of Throat | 🗌 | 🗌 | Tonsillitis | 🗌 | 🗌 | Weakness of Leg |
| 🗌 | 🗌 | Infertility | 🗌 | 🗌 | Ulcers | 🗌 | 🗌 | Weakness of Knee |
| 🗌 | 🗌 | Intestinal Gas | 🗌 | 🗌 | Vertigo | 🗌 | 🗌 | Leg Cramps |
| 🗌 | 🗌 | Irregular Heart Beat | 🗌 | 🗌 | Vision Problems | 🗌 | 🗌 | Numbness of Legs/Feet |
| 🗌 | 🗌 | Irritability | 🗌 | 🗌 | Vomiting Blood | 🗌 | 🗌 | Ankle/Foot Pain |
| 🗌 | 🗌 | Irritable Bowel |  |  |  | 🗌 | 🗌 | Cold Feet |
|  |  |  |  |  | **NECK ( L / R )** | 🗌 | 🗌 | Numbness/Tingling in Toes |
|  |  |  | 🗌 | 🗌 | Neck Pain |  |  |  |
|  |  |  | 🗌 | 🗌 | Neck Feels Out of Place |  |  |  |
|  |  |  | 🗌 | 🗌 | Grinding/Popping in Neck |  |  |  |
|  |  |  | 🗌 | 🗌 | Muscle Spasms in Neck |  |  |  |

**YOUR HEALTH GOALS**

Your top three health goals:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TRAUMAS: Physical Injury History**

Have you ever had any significant falls, surgeries, or other injuries as an adult? 🗌YES 🗌NO
If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notable childhood injuries? 🗌YES 🗌NO If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Youth or college sports? 🗌YES 🗌NO If yes, please list major injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any auto accidents? 🗌YES 🗌NO If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise Frequency? 🗌 None 🗌 1-2x per week 🗌 3-5x per week 🗌 Daily
What types of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you normally sleep? 🗌Back 🗌Side 🗌Stomach Do you wake up 🗌Refreshed and ready 🗌Stiff and tired

Do you commute to work? 🗌YES 🗌NO If yes, how many minutes per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any problems with flexibility. (Ex- Putting on shoes/socks, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours per day do you typically spend sitting at a desk or on a computer, tablet or phone? \_\_\_\_\_\_\_\_\_\_\_\_\_
Please list any drugs/medications/vitamins/herbs/other that you are taking, and why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACTIVITIES OF LIFE**
Please list various activities of daily life that are currently being affected by your spinal condition.

Primary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Third: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WOMEN ONLY: This is to certify that to the best of my knowledge I am not pregnant, and the above doctors and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE READ AND SIGN BELOW**

I hereby authorize payment to be made directly to Mahan Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Mahan Family Chiropractic for all services I receive at this office. **Failure to cancel a scheduled appointment within 24-hours or “no-showing” the scheduled appointment will result in a charge on your account for the full amount of the missed visit.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
**Patient or Authorized Person’s Signature Date Completed**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
**Doctor’s Signature Date Form Reviewed**