**Rehab and Revive Physical Therapy, Inc.**

14661 Myford Rd Suite C

Tustin, CA 92780

Phone (714) 900-3880

Fax (714) 731-0932

[hello@rehabandrevive.com](mailto:hello@rehabandrevive.com)

**Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apartment/Suite: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Method of Communication:  Phone Call  Text Message  Email

Referred By:  Yelp  Google Reviews  Youtube  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent / Responsible Party**

Please complete this section if patient is a minor or responsible party is different from patient.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apartment/Suite: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signed (Parent/Responsible Party): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Signed (Patient/Client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

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**Informed Consent Form**

I, , do hereby consent to the following treatments/exercises:

**Initial next to ALL** applicable treatments/exercise: (Please see Description of Treatment Page for details of each.)

Physical therapy care

Physical training/cardiovascular exercise/therapeutic exercise program

Visceral (Organ) mobilization

(Fertility) mobilization of reproductive organs

Full body therapy and manual work including (spine, skull, sacrum, and coccyx)

Manual therapy of the mouth and jaw

Neuromechanical Therapy and Nerve Mobilization

I have been informed and understand that physical exercise and physical therapy (including but not limited to manual manipulation to the body, nerve tissue, and viscera) have been associated with certain benefits, including reduction or elimination of pain, discomfort, and/or stress. The likelihood of success varies with each patient and his or her individual conditions, medical history, and/or ailments. However, the typical patient generally tends to find temporary if not permanent reduction or elimination of pain, discomfort, and/or stress.

In addition to benefits, I acknowledge and understand that the physical treatment(s)/exercise(s) referenced above has a risk of serious injury and/or significant potential complications relating to musculoskeletal injury, spinal injury, abnormal blood pressure responses, and in rare instances, temporary or permanent paralysis, heart attack and/or death.

I acknowledge that I have disclosed all information on the PATIENT INTAKE FORM regarding my past medical history. I have consulted or have had reasonable opportunity to consult with a licensed physician, and based thereon, affirm that, to my knowledge, I am physically capable of accepting the physical therapy treatment set forth above. I have also consulted with Rehab and Revive Physical Therapy, and have had a reasonable opportunity to inquire into the treatment(s)/exercise(s), benefits and risks referenced above, and affirm that Rehab and Revive Physical Therapy has answered any such inquiries to my satisfaction.

I acknowledge that some of the treatments may be painful during treatment. I also acknowledge that soreness and/or pain may persist, usually up to one week, after treatment. I further acknowledge that treatment may not eliminate or even reduce any pain I am experiencing prior to treatment; and that there is the rare possibility that pain may develop from treatment that, in rare instances, may be permanent.

I acknowledge that both Rehab and Revive Physical Therapy, Inc. and I each have the right to decline treatments, plan of care, or discontinue any treatment/exercise session at any time.

I have read and understand the above INFORMED CONSENT FORM, and am hereby voluntarily signing my name below to authorize Rehab and Revive Physical Therapy, Inc. to proceed with the treatments/exercises set forth above.

**Signed (Patient/Client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Description of Treatments**

**Physical Therapists** are state licensed health care providers who are experts in the examination and treatment of problems that affect people's abilities to move and function. These problems may include functional (task-related, postural, and mechanical), biomechanical, neuromuscular (nerves, motor planning, and motor control), musculoskeletal (bones, joints, tendons, ligaments, and muscles), visceral (organ related), cardiovascular/pulmonary (heart and lung), and integumentary (skin) that contribute to physical limitations.

**Physical therapy care:**

Care provided or supervised by a licensed Physical Therapist. Care includes proper evaluation and examination, clinical diagnosis, treatment plan, and therapy goals. Reassessment and discharge planning are a vital component to the care plan process to help provide everlasting change and a plan of action for the patient.

**Full Body and Manual Therapy:**

Within the physical therapy profession, manual therapy is defined as a clinical approach utilizing skilled, specific hands-on techniques, including but not limited to manipulation/mobilization, used by the physical therapist to diagnose and treat soft tissues as well as joint structures for the purpose of: modulating pain, increasing range of motion (ROM), reducing or eliminating soft tissue inflammation, inducing relaxation, improving contractile, non-contractile tissue repair (neural-dural), extensibility, stability, facilitating movement, and improving function.

<http://en.wikipedia.org/wiki/Manual_therapy>

**Physical Training/Cardiovascular Exercise/Therapeutic Exercise Program:**

A program developed specifically for the patient needs. Training and exercise will elevate heart rate and stress the bones, muscles, ligaments and joints.

**Visceral (Organ) Mobilization:**

Is the external use of manual therapy to stretch surrounding areas and/or repositioning of organs that may have adhered to each other or other structures in the body.

**(Fertility) Mobilization of Reproductive Organs:**

Is the use of manual therapy externally to stretch surrounding areas of the female reproductive organs and reposition the ovaries that may have adhered to each other or other structures in the body.

**Manual Therapy of the Mouth Jaw:**

Consist of external manual therapy of the facial bones surrounding the temporomandibular joint (TMJ). In some instances, intra-oral (inside the mouth) may be indicated to release muscles around the TMJ for relief and restoration of normal biomechanics of the jaw.

**NeuroMechanical Therapy (NMT) and Nerve Mobilization**

NMT is an innovative system of organizing treatment through mobilizing nervous tissue with various methods applied from both evidence informed research, as well as techniques developed and inspired by Dr. Justin Lin and learned techniques from the Integrative Systems Model, Barral Institute, Functional Manual Therapy, and Upledger Institute.



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**Patient Intake Form**

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Tustin, CA 92780

Phone (714) 900-3880 Fax (714) 773-10932

[hello@rehabandrevive.com](mailto:hello@rehabandrevive.com)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:  Male  Female

Gender:  Male  Female  Transgender Male  Transgender Female  Gender Variant/Non-Conforming  Decline to Specify

Ethnicity/Race:  American Indian or Alaska Native  Hispanic or Latino  Asian  Black or African American

 Native Hawaiian or other Pacific Islander  White  Decline to specify  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate Date of Injury or Onset of Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving treatment for the condition above? If so, when and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies? If so, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you coming for treatment because of an accident or work related injury? If YES, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all PRESCRIBED medication and corresponding dosage you are CURRENTLY taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you taken any OVER-THE-COUNTER (OTC) medications in the past TWO WEEKS? If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had surgery or conditions that required hospitalizations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any notable scars/scar tissue? If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been in any major car accidents? If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you prefer to sleep?  Side  Back  Stomach

# Please rate your current level of pain on the following scale (circle one):

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| no pain |  |  |  |  | tolerable |  |  |  |  | worst imaginable pain |

Please rate your worst level of pain in the last 2 weeks on the following scale (circle one):

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| no pain |  |  |  |  | tolerable |  |  |  |  | worst imaginable pain |

**Please check other medical conditions you have or have had. Please then specify whether it is current or was in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Arthritis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Osteoporosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Hepatitis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | High Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Tuberculosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Heart Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Recurrent Infections Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Heart Attack: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Thyroid Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Stroke: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Concussions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Vascular Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Hernia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Asthma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Kidney Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Diabetes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Depression: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Anemia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Anxiety: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Epilepsy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Other Conditions Not Listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | HIV/AIDS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Please check any general health conditions you have or have had. Please then specify whether it is current or was in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Pacemaker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Numbness/Tingling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Hypersensitivity to Heat: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Headaches: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Hypersensitivity to Cold: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Metal in Body: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Shortness of Breath: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Surgical Implants: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Chronic Cough: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Smoking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Dizziness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Bowel Dysfunction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Fainting Spells: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Night Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Nausea/Vomiting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Painful Urination or Leaky Bladder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Swelling in Ankles: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Urination Frequency Changes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Severe Fatigue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Sexual Dysfunction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Recent Weight Loss/Gain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Falls/Tumbles: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Fever/Chills: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Consistent Tripping: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

### **Pain Diagram Instructions:** Please use the diagram to indicate the symptoms you have experienced. Use the key to indicate the type of symptoms.



|  |  |
| --- | --- |
| **Key:** |  |
| Pins and Needles | = ooooo |
| Burning | = xxxxxx |
| Stabbing | = / / / / / / |
| Deep Ache | = zzzzzz |
| Stiffness | = ssssss |
| Swelling | = bbbbbb |

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Payment and Office Policy Agreement**

**Please initial next to each payment/office policy. Please note: you are not necessarily required to purchase a program or package. Initialing next to those policies is stating that you understand the policy for each if you do decide to purchase a program or package.**

**Payment Method:**

I understand that Rehab and Revive Physical Therapy (RRPT), Inc. accepts Cash, Personal Check, and Major Credit Cards. All personal checks that are returned to Rehab and Revive will incur a $100 surcharge. **\_\_\_\_\_\_\_\_ (Initial)**

**Time of Payment:**

I agree to pay my balance in full each visit unless other payment arrangements are made by RRPT**. \_\_\_\_\_\_\_(Initial)**

**Cancellation and No-Show Policy**

**I agree that cancellations of less than forty-eight (48) hours or missing my appointment will result in a fee of the most current FULL SESSION RATE or FORFEIT a session from package or program.** If given between twenty-four (24) and forty-eight (48) hours’ notice, Rehab and Revive will actively try to fill the appointment with someone on the waiting list. If Rehab and Revive can successfully fill the session, there will be no charge for the late cancellation. Please keep in mind this is a courtesy and Rehab and Revive may not be able to fill the session in that time frame. Any late cancellations that are given less than twenty-four hours notice WILL incur the late cancellation fee as Rehab and Revive will not have enough time to contact those on the waiting list. **\_\_\_\_\_\_\_(Initial)**

**Package Deals:**

I agree to pay all package deals **in full** at the time of purchase (that unless otherwise agreed upon by RRPT). A package agreement will be issued outlining the details of the package. I agree that the promotional value for the 5 session package and the 10 session package will **expire in 1 year** from the date of purchase, unless otherwise agreed upon by Rehab and Revive Physical Therapy. The unused balance does not expire, however, and the credit can be used to repurchase a new package in cases of package at the current rate. I understand that the packages are **non-refundable and non-transferrable**. Only the client name listed and signed on the package agreement can use the sessions. **\_\_\_\_\_\_\_(Initial)**

**Program Deals:**

I agree to pay the remainder of my program at the time of the initial evaluation or before continuing with the remainder of my treatment. I agree that my program credit **will expire 1 year** from the date of my first visit, unless otherwise agreed upon by Rehab and Revive Physical Therapy. The unused balance does not expire, however, and the credit can be used to repurchase new sessions or packages at the current rate. I understand that once the program has been completed, I will be locked in at a discounted per session rate for any subsequent sessions. I understand that the packages are **non-refundable and non-transferrable**. Only the client name listed and signed on the package agreement can use the sessions.**\_\_\_\_\_\_\_(Initial)**

**Release of Information**

I authorize the release of any medical or other information necessary to process payment for medical services and/or products rendered. In this process RRPT will seek recovery of processing fees, administrative fees, court fees, collection services, and chargeback fees, with a 15% interest incurred daily from the day debt has first occurred. **\_\_\_\_\_\_\_(Initial)**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legally Authorized Signature (on behalf of patient above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Rehab and Revive Physical Therapy, Inc.**

**Client HIPAA Acknowledgement and Consent Form**

14661 Myford Rd Suite C

Tustin, CA 92780

Phone (714) 900-3880 Fax (714) 773-10932

[hello@rehabandrevive.com](mailto:hello@rehabandrevive.com)

**Consent to Email, Text, and Call for Appointment Reminders and Other Healthcare Communications**

Rehab and Revive Physical Therapy clients may be contacted via email, text messaging and/or phone call to remind you of an appointment and/or to provide general health reminders/information.

If at any time I provide an email or phone number at which I may be contacted, I consent to receiving appointment reminders and other healthcare communication/information at that email or phone number address from the Practice.

**\_\_\_\_\_\_\_(Initial)** I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is (include area code) **Phone Number:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The email address that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is **Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Rehab and Revive Physical Therapy does not charge for this service, but standard text messaging and telephone rates may apply as provided in your phone and/or wireless plan (contact your carrier for pricing and details).**

**Rehab and Revive’s appointment reminder system will soon allow you to receive reminders emailed and either texted messaged or called. Please choose how you would like to receive your appointment reminders. Remember you can choose a combination of email AND EITHER text messaging OR a phone call, but not a phone call and a text. You may also choose just one of the options.**

** Email**

**AND/OR**

**(pick one)**

** Text Message  Phone Call**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Revocation: I hereby revoke my request for future communications via email, phone call and/or text message.**

 I hereby revoke my request to receive any (future appointment reminders, feedback, and general health information) via text messages.

 I hereby revoke my request to receive any (future appointment reminders, feedback, and general health information) via email.

 I hereby revoke my request to receive any (future appointment reminders, feedback, and general health information) via phone call.

***NOTE: This revocation only applies to communications from this Practice.***

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient/Patient Representative Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tampa Scale for Kinesiophobia**

### **(Miller, Kori and Todd 1991)**

1 = strongly disagree 2 = disagree

3 = agree

4 = strongly agree

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. I’m afraid that I might injure myself if I exercise | 1 | 2 | 3 | 4 |
| 2. If I were to try to overcome it, my pain would increase | 1 | 2 | 3 | 4 |
| 3. My body is telling me I have something  dangerously wrong | 1 | 2 | 3 | 4 |
| 4. My pain would probably be relieved if I were to exercise | 1 | 2 | 3 | 4 |
| 5. People aren’t taking my medical condition  seriously enough | 1 | 2 | 3 | 4 |
| 6. My accident has put my body at risk for the rest of my life | 1 | 2 | 3 | 4 |
| 7. Pain always means I have injured my body | 1 | 2 | 3 | 4 |
| 8. Just because something aggravates my pain does not mean it is dangerous | 1 | 2 | 3 | 4 |
| 9. I am afraid that I might injure myself  accidentally | 1 | 2 | 3 | 4 |
| 10. Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening | 1 | 2 | 3 | 4 |
| 11. I wouldn’t have this much pain if there weren’t something potentially dangerous going on in my body | 1 | 2 | 3 | 4 |
| 12. Although my condition is painful, I would be better off if I were physically active | 1 | 2 | 3 | 4 |
| 13. Pain lets me know when to stop exercising so  that I don’t injure myself | 1 | 2 | 3 | 4 |
| 14. It’s really not safe for a person with a condition like mine to be physically active | 1 | 2 | 3 | 4 |
| 15. I can’t do all the things normal people do because it’s too easy for me to get injured | 1 | 2 | 3 | 4 |
| 16. Even though something is causing me a lot of  pain, I don’t think it’s actually dangerous | 1 | 2 | 3 | 4 |
| 17. No one should have to exercise when he/she is in pain | 1 | 2 | 3 | 4 |

Reprinted from:

*Pain*, Fear of movement/(re) injury in chronic low back pain and its relation to behavioral performance, 62, Vlaeyen, J., Kole-Snijders A., Boeren R., van Eek H., 371.

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**Rehab and Revive Physical Therapy, Inc.**

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Phone (714) 900-3880

Fax (714) 731-0932

[hello@rehabandrevive.com](mailto:hello@rehabandrevive.com)

# Notice of Privacy

## THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

We respect our legal obligation to keep health information that identifies you private.

We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

#### **TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment or healthcare operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you, examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other healthcare or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). “Healthcare operations” mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense or legal matters; business planning; and outside storage of our records.

#### **USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

* When a state or federal law mandates that certain health information be reported for a

specific purpose;

* For public health purposes, such as contagious disease reporting, investigative or surveillance; and notices to and from federal food and drug administration regarding drugs or medical devices;
* Disclosures to government authorities about victims of suspected abuse, neglect or domestic violence;
* Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigative of possible violations of healthcare laws;
* Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
* Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
* Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ and/ or tissue donations;
* Uses or disclosures for health-related research;
* Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
* Disclosures of de-identified information;
* Disclosures relating to worker’s compensation programs;
* Disclosures of a “limited data set” for research, public health, or healthcare operations;
* Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
* Disclosures to “business associates” who perform healthcare operations for us and who commit to respect the privacy of your health information.

#### **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written “authorization form”. The content of an “authorization form” is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea.

Sometimes, you may initiate the process if it’s your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the uses or disclosures. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send it to the office named at the beginning of this Notice.

#### **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:

* Ask us to restrict our uses and disclosures for purposes of treatment (except emergency

treatment), payment or healthcare operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office at the address or fax number shown at the beginning of this Notice.

* Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by sending an e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office at the address or fax number shown at the beginning of this Notice.
* Ask to see or get photocopies of your health information. By law, there are a few limited

situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office at the address or fax number shown at the beginning of this Notice.

* Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know received the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request to the address or fax number shown at the beginning of this Notice.
* Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or healthcare operations; disclosures with your healthcare authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it. By law, we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office at the address or fax number shown at the beginning of this Notice.
* Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you have one electronically or in paper form already. If you want additional paper copies, send a written request to the office at the address or fax number at the beginning of this Notice.

#### **OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this Notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new Notice in our office, have copies available in our office, and post it on our website.

#### **COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us, the U.S. Department of Health and Human Services, or the Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office at the address, or fax number shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

#### **FOR MORE INFORMATION**

If you need more information about our privacy practices, call or visit the office shown at the beginning of this Notice.

**-------------------------------------------------------------------Tear Here------------------------------------------------------------------**

**ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I have read and received a copy (or will be maintained on file), of Rehab and Revive Physical Therapy, Inc.’s Notice of Privacy Practices.

**Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**