|  |  |
| --- | --- |
| Glanmire Chiropractic Logo | Tel: 021-4824450  Fax: 021-4820766  Eastcliffe House, Glanmire, Co. Cork  E-mail: gcc@live.ie |

**CONFIDENTIAL PATIENT INFORMATION**

**Personal Information**

|  |  |
| --- | --- |
| **Full name: Date of Birth:** | |
| **Address:** | |
| **Mobile phone:** | **Home/Work phone:** |
| **Email address:** | **G.P.:** |
| **No. of children:** | **Pregnant? Yes** □ **No** □ |
| **Height:** | **Weight:** |
| **Marital status:** | **Spouse/guardian name:** |
| **Occupation:** |  |

**Who may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Addressing What Brought You Into This Office:**

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the* ***“General Health History”****.*

**Health Concerns**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please list your health concerns according to their severity | Rate of severity  1 = mild  10 = worst imaginable | When did this episode start? | If you had this condition before, when? | Did the problem begin with an injury? | % of the time pain is present |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Since the problem started is it: About the same? □ Getting better? □ Getting worse? □

What have you done for this condition? Was it of benefit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I do (do not) have a family history of this or similar symptoms (Please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Which activities aggravate your condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What Other doctors you have seen for this condition:**

|  |  |
| --- | --- |
| “Limited Scope” Chiropractor (focuses mainly on neck and back pain) | □ |
| “Wellness” Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns) | □ |
| Medical Doctor | □ |
| Dentist | □ |
| Other (please describe) | □ |

**Doctor’s details:**

|  |  |  |
| --- | --- | --- |
| Name: | | Address: |
| When did you see them? | | |
| What did they say was wrong? | | |
| Did it help? | What did they do? | |

|  |  |  |
| --- | --- | --- |
| Name: | | Address: |
| When did you see them? | | |
| What did they say was wrong? | | |
| Did it help? | What did they do? | |

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc?

(i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is this condition interfering with any of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Work □ | Sleep □ | Daily routine □ | Sports/exercise □ | Other □ (please explain): |

**General Health History**

*Often times, accumulation of life’s stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!*

**Have you had any surgery?** (Please include all surgery)

|  |  |  |
| --- | --- | --- |
| 1. Type: | When? | Doctor |
| 2. Type: | When? | Doctor |
| 3. Type: | When? | Doctor |
| 4. Type: | When? | Doctor |

**Have you had any accidents and/or injuries: auto, work-related, or other?** (Especially those related to your present problems).

|  |  |  |
| --- | --- | --- |
| 1. Type: | When? | Hospitalised? Yes □ No □ |
| 2. Type: | When? | Hospitalised? Yes □ No □ |
| 3. Type: | When? | Hospitalised? Yes □ No □ |

**Have you ever had x-rays/scans taken?**

|  |  |  |
| --- | --- | --- |
| Area of body: | When? | Where? |
| Area of body: | When? | Where? |

Do you wear orthotics or heel lifts? Yes □ No □

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medicines and Supplements**

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

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

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Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

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

**Past Health History**Please mark the following conditions you may have had or have now (- have had + have now):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| □ Alcoholism | □ Allergy | □ Anemia | □ Arteriosclerosis | □ Arthritis | □ Asthma |
| □ Back Pain | □ Cancer | □ Cold Sores | □ Constipation | □ Convulsions | □ Depression |
| □ Diabetes | □ Diarrhea | □ Eczema | □ Emphysema | □ Epilepsy | □ Gall Bladder |
| □ Gout | □ Headaches | □ Heart Attack | □ Heart Disease | □ High Blood Pressure | □ HIV (Aids) |
| □ Irregular Periods | □ Low Blood Sugar | □ Malaria | □ Measles | □ Menstrual Cramps | □ Migraines |
| □ Miscarriage | □Multiple Sclerosis | □Mumps | □ Neck Pain | □ Nervousness | □ Neuritis |
| □ Pleurisy | □ Pneumonia | □ Polio | □ Rheumatic Fever | □ Ringing in ears | □Sinus Problems |
| □ Stroke | □ Thyroid Problems | □Tuberculosis | □ Ulcers | □ Venereal Disease | □ Whooping Cough |

Other (please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Stressors**

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. **Physical stress** (falls, accidents, work postures, etc.)
   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Bio-chemical stress** (smoke, unhealthy foods, missed meals, don’t drink enough water, drugs/alcohol, etc.)
   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Psychological or mental/emotional stress** (work, relationships, finances, self-esteem, etc.)
   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):**

|  |  |  |
| --- | --- | --- |
| At work: | At home: | At play: |

**On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Eating habits: | Exercise habits: | Sleep: | General health: | Mind set: |

**How do you grade your physical health?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Excellent □ | Good □ | Fair □ | Poor □ | Getting better □ | Getting worse □ |

**How do you grade your emotional/mental health?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Excellent □ | Good □ | Fair □ | Poor □ | Getting better □ | Getting worse □ |

**Is there anything else which may help to better understand you which has not been discussed?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Why are you here at this point in time?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO HOLD FILE AND DATA PROTECTION POLICY**

Pursuant to the Data Protection Acts 1998 and 2003, we are required to advise patients of our Data Protection Policy.

**POLICY**

As part of a patient’s records, this Clinic retains information for the purposes of consultation for treatment, recording treatments and payments and use by third party medical practitioners and third party payers such as health insurance companies.

All paper files and information contained within a patient’s records may be electronically scanned and stored on computer file for as long as the relevant patient remains a patient of this Clinic, and for a period of at least 8 years thereafter. Paper records will be retained for the same period.

All information held both in paper and electronic formats will be accessible only by the staff of this Clinic who are directly involved in the data entry and processing of patient records. Other than for the purposes stated here, information will not be released except with the patient’s written consent, or as required by law.

**CONSENT**

I hereby acknowledge that I have read the above Data Protection Policy and hereby give consent to the maintenance of my records for the purposes outlined within said Policy.

**Signed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT or PARENT/GUARDIAN (If under 18 consent must be given by a parent or legal guardian.)

**CONSENT TO PHYSICAL EXAMINATION**

I consent to physical examination by my Chiropractor, to include (as needed) foot examination and Gaitscan.

**Signed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT or PARENT/GUARDIAN (If under 18 consent must be given by a parent or legal guardian.)

**CONSENT TO CONTACT YOUR HEALTHCARE PROVIDER**

I hereby authorise you to contact my Healthcare Providers to obtain reports and/or information pertaining to myself and to write to him/her following my treatment.

**Signed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT or PARENT/GUARDIAN (If under 18 consent must be given by a parent or legal guardian.)

**INFORMED CONSENT TO CHIROPRACTIC TREATMENT**

The chiropractor, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, has explained his opinion/assessment of my condition and prognosis to me. He also explained the relevant treatment options that are available to me and the associated risks, including in his opinion the potential negative outcome/s or risks of not having the treatment.

The explanation, including potential risks and benefits that are specific to me I fully understand. I have had the opportunity to discuss and clarify any concerns with the chiropractor.

I understand that the result/outcome of the treatment cannot be guaranteed. I also understand that I can seek another opinion as to my condition/treatment if I desire to do so before I commence treatment.

Having fully understood all of this and having fully considered my options I consent to receive the treatment I have discussed with my Chiropractor and/or anyone authorized by him.

**CONSENT**

**Signed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT or PARENT/GUARDIAN (If under 18 consent must be given by a parent or legal guardian.)

**Witness** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_