Thrive Healing Arts Center L.L.C.

Dr. Janet T. McKush

Chiropractic Physician

1751 Shoreline Boulevard, Prior Lake, MN 55379

952-226-2229 *thrivehealingartscenter.com*

Name:_____ Date:_____

Address:_____

Street City State Zip

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email:_____

Date of Birth: _____ / _____ / _____ Age: _____ Gender: M / F

Current Marital Status (circle one): single married separated divorced widowed

Name of Significant Other: _____Number of Children:_____

Children's Names / Ages: _____

Employer: _____Employed: FT PT student

Employers Address: _____

Street City State Zip

Job Description: _____ Work Intensity Level: _____

How did you hear about our office? _____

Reasons you are consulting our office: (check all that apply)

- o I have a specific problem / pain and want help with eliminating this problem / pain.
- o I am willing to make lifestyle changes with diet and exercise to facilitate healing.
- o I have no current symptoms. I am here for wellness care and to optimize my health.

Thrive Healing Arts Center LLC is a fee-for-service practice. **Payment is expected at the time of service.** Credit card, check and cash payments are accepted. You should notify the doctor if you are in an auto accident or experience an injury at your place of work. In these instances Dr. McKush will refer you to a qualified provider that will render care and assist you in submitting claims for your injury.

Appointment time is limited, therefore a missed appointment fee will be incurred unless cancellation is made the day prior to your appointment ($50 or $90 depending on appointment length/type).

I understand and agree that health insurance policies are an arrangement between my insurance carrier/s and me. I understand that Dr. McKush will provide me with a statement to submit to my insurance company or HSA, and any reimbursements should be pursued by and paid to me. Should funds be mistakenly paid to Thrive Healing Arts Center LLC, I will be credited or reimbursed.

I understand and agree that all services, supplements, or healing supplies rendered to me at Thrive Healing Arts Center LLC are charged directly to me and that I am personally responsible for payment.

Patient Signature: _____ Date: _____

Name: _____ Date: _____

Reason for visit: _____

Are you recovering from a cold or flu? Y N Are you pregnant? Y N

When did your symptoms begin?_____ Have you previously had similar symptoms? Y N

Have your symptoms changed in any way? Y N If so, how? _____

Does anything make your symptoms better? _____

Does anything make your symptoms worse? _____

Do they interfere with: work sleep daily routine recreation other: _____

What is your opinion about the cause? _____

Have you seen any other providers for this condition?

Provider	Treatment Given	Helpful?	Treatment dates
_____	_____	Y N	_____
_____	_____	Y N	_____

What types of therapy have you tried for this problem(s)?

☐ diet modification ☐ fasting ☐ vitamin/mineral ☐ herbs ☐ homeopathy ☐ chiropractic ☐ acupuncture ☐ conventional drugs

☐ other_____

List current health problems for which you are being treated_____

Current medications_____

Circle the level of stress you are experiencing on a scale of 0 to 10 (0 being the lowest): 1 2 3 4 5 6 7 8 9 10

Major causes of stress: (job change, work, home, finance, legal issues, etc.)

_____

_____

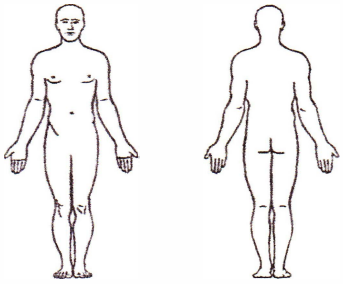
Are you in pain? Y N

Describe the location:

_____

_____

Mark an X on the picture to show where you feel pain.



What does the pain feel like? (circle all that apply)

Sharp burning stabbing dull achy sore

weak throbbing tender numb tingling shooting tight cramping

pulling surface deep constant comes and goes

Rate your pain intensity (0=No pain, 10=Excruciating pain)<0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10>

Activities that are painful to perform: sitting walking bending lying down other: _____

Recent Health History

Have you had any recent weight change (loss or gain)? Y N

Have you been trying to lose weight? Y N

Are you feeling unusually tired or fatigued? Y N

Have you had a recent abnormal temperature? Y N

Are you having difficulty with urination or bowel movements? Y N

Do you have night sweats? Y N

Have you had long-term steroid use? Y N

Have you had any recent infections? Y N

Have you been diagnosed with cancer or any other illnesses? Y N

Past Health History:

Date of last physical exam:_____

Discuss important results of these tests: _____

GENERAL
- ☐ Chills
- ☐ Confusion
- ☐ Convulsions
- ☐ Dental Problems
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Muscle Jerking
- ☐ Nervousness
- ☐ Numbness or Tingling
- ☐ Paralysis
- ☐ Sweats

EYE,EAR,NOSE,THROAT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache or Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

SKIN
- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sores That Won't Heal

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

GASTROINTESTINAL
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion or Heart Burn
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting

Do you have any allergies? Y N If so, list

GENERAL SYMPTOMS: Check Symptoms you have had in the past year

Major Hospitalizations, Surgeries, Injuries:

Year	Operation, illness, injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you been involved in a moving vehicle collision? Y N

Please list approximate dates and severity: mild, moderate or extreme.

Automobile: _____

Bus, Motorcycle: _____

Bicycle, Rollerblades, etc: _____

Sports and Leisure

Were you previously active in any particular sports that you are now no longer able to do? Y N

Please list: _____

Are there activities in which you spend any length of time in a particular position (TV, reading, musicians, etc.)?

Describe: _____

During the day I: (circle all that apply)

Sit Stand Walk Do phone work Drive Do mechanical work Do repetitive work Do heavy lifting

Do you use safety equipment like bike helmets, wrist guards and seat belts? Y N

Do you wear arch supports orthotics heel lifts?

How much sleep do you get? _____hours/night Do you sleep on your: side back stomach?

Chemical Exposure

Is your job associated with potentially harmful chemicals (e.g. pesticides, radioactivity, solvents) or health and/or life threatening (e.g. fireman, farmer, miner) activities? Y N

Describe: _____

Please indicate any **medications or drugs** you have taken in the past by circling P, or if you are currently taking it circle C.

Allergy/Cold/Flu P C Aspirin/Tylenol/Ibuprofen P C Laxatives P C

Antacids	P	C	Birth Control Pills	P	C	Lithium	P	C
Anti-anxiety	P	C	Blood pressure meds	P	C	Pain medications	P	C
Antibiotic	P	C	Cortisone	P	C	Pep pills/Stimulants	P	C
Antidepressant	P	C	Diabetic medications	P	C	Recreational	P	C
Antifungal	P	C	Heart medications	P	C	Relaxant/Sleeping pills	P	C
Anti-inflamatory	P	C	Hormones	P	C	Thyroid medications	P	C
Antiparasitic(worms)	P	C	Insulin	P	C	Ulcer medications	P	C
Other	P	C	List:_____					

What immunizations have you received?_____

Medical History: CHECK ALL THAT APPLY

☐ AIDS	☐ High Cholesterol	☐ HIV Positive	☐ Prosthesis
☐ Alcoholism	☐ Circulatory Problems	☐ Infection, chronic	☐ Rheumatoid Arthritis
☐ Allergies	☐ Colitis	☐ Inflammatory bowel	☐ Rheumatic Fever
☐ Anemia	☐ Dental Problems	☐ Irritable bowel	☐ Scarlet Fever
☐ Anorexia	☐ Depression	☐ Kidney Disease	☐ Seasonal Affective Disorder
☐ Appendicitis	☐ Diabetes	☐ Learning disabilities	☐ Sexually transmitted disease
☐ Arthritis	☐ Eating Disorder	☐ Liver Disease	☐ Sinus issues
☐ Asthma	☐ Emphysema	☐ Measles	☐ Skin problems
☐ Autoimmune disease	☐ Epilepsy	☐ Mental illness	☐ Stroke
☐ Bleeding Disorders	☐ Eye, ear, nose, throat, prob	☐ Migraine Headaches	☐ Thyroid Problems
☐ Breast Lump	☐ Fibromyalgia	☐ Miscarriage	☐ Tonsillitis
☐ Bronchitis	☐ Food intolerance	☐ Mononucleosis	☐ Tuberculosis
☐ Bulimia	☐ Genetic disorder	☐ Multiple Sclerosis	☐ Tumors, Growths
☐ Cancer	☐ Glaucoma	☐ Mumps	☐ Typhoid Fever
☐ Carpal Tunnel	☐ Goiter	☐ Neurological Disorder	☐ Ulcers
☐ Cataracts	☐ Gonorrhea	☐ Obesity	☐ Vaginal Infections
☐ Chemical Dependency	☐ Gout	☐ Osteoporosis	☐ Varicose veins
☐ Chicken Pox	☐ Heart Disease	☐ Pacemaker	☐ Venereal Disease
☐ Chronic Fatigue	☐ Hepatitis	☐ Pneumonia	☐ Whooping Cough
☐ Herpes	☐ Hernia	☐ Polio	☐ Other _____
		☐ Prostate Problem	

MEN

☐ BPH
☐ Prostate Cancer
☐ Decreased Sex Drive
☐ Infertility
☐ Other_____

WOMEN

☐ Breast Cancer	☐ Infertility
☐ Decreased sex drive	☐ Menstrual irregularities
☐ Endometriosis	☐ Pelvic inflammatory disease
☐ Fibrocystic breasts	☐ PMS
☐ Fibroids/ovarian cysts	☐ Vaginal infections
☐ Hot Flashes	☐ Other _____

☐ Corrective Lenses ☐ Dentures ☐ Hearing Aid ☐ Medical Devices/prosthetics/implants, describe: _____

_____

Recent changes in your ability to: ☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations ☐ move

Strong like for ay of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Strong dislike for ay of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Do you: ☐ prefer warmth (i.e.food, drink, weather) ☐ prefer cold (i.e.food, drink, weather) ☐ No preference

Is your sleep disturbed at the same time every night? Y N if yes, what time? _____

Time of day you have the most energy or least symptoms:			Time of day you have the least energy or most symptoms:		
☐ 7a.m-9a.m.	☐ 9am – 11am	☐ 11am – 1pm	☐ 7a.m-9a.m.	☐ 9am – 11am	☐ 11am – 1pm
☐ 1pm – 3pm	☐ 3pm – 5pm	☐ 5pm – 7pm	☐ 1pm – 3pm	☐ 3pm – 5pm	☐ 5pm – 7pm
☐ 7pm – 9pm	☐ 9pm – 11pm	☐ 11pm – 1am	☐ 7pm – 9pm	☐ 9pm – 11pm	☐ 11pm – 1am
☐ 1am - 3am	☐ 3am – 5am	☐ 5am – 7am	☐ 1am - 3am	☐ 3am – 5am	☐ 5am – 7am

Name: Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a purification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloated feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4

Total: ____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4

Total: ____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4

Total: ____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Rheumatoid arthritis	0 1 2 3 4
c. Osteoarthritis	0 1 2 3 4
d. Stiffness or limited movement	0 1 2 3 4
e. Pain or aches in muscles	0 1 2 3 4
f. Recurrent back aches	0 1 2 3 4
g. Feeling of weakness or tiredness	0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4

Total: ____

Section I Total: ____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4

b. How often are pesticides used in your home? 0 1 2 3 4

c. How often do you have your home treated for insects? 0 1 2 3 4

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0 1 2 3 4

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

Total: _____

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3

b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a purification program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.

Thrive Healing Arts Center L.L.C.
Patient Consent for Treatment

I hereby request and consent to the performance of chiropractic adjustments and adjunctive procedures, which may include acupuncture and/or Applied Kinesiology testing, and /or nutritional recommendations, on me (or the patient named below, for whom I am legally responsible) by Dr. Janet McKush D.C. with Thrive Healing Arts Center L.L.C.

Chiropractic

I have had the opportunity to discuss with the doctor of chiropractic the nature and purpose of chiropractic adjustments and other procedures. I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits nor is there guarantee to the outcome of these procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the provider to be able to anticipate and explain all of the risks and complications, and I wish to rely upon the provider to exercise judgment during the course of the procedure which the provider feels at the time, based upon the facts known to her, is in my best interest.

Acupuncture

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks with acupuncture are spontaneous miscarriage, nerve damage and organ puncture (including lung puncture or pneumothorax). Infection is another possible risk, although the certified chiropractic acupuncturist Dr. Janet McKush uses sterile disposable needles and safe environment. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

I do not expect the certified chiropractic acupuncturist Dr. Janet McKush to be able to anticipate and explain all risks and complications during treatment, and wish to rely on her to exercise judgment in the course of treatment which she thinks at the time, based on the facts known, is in my best interest. I understand that results are not guaranteed.

Applied Kinesiology

I have requested a chiropractic evaluation, which at Thrive Healing Arts Center L.L.C. utilizes Applied Kinesiology /muscle testing for analysis in conjunction with

other conventional chiropractic testing procedures. I understand that the practice of Applied Kinesiology testing originated in 1964 by Dr. George Goodheart, whose techniques are utilized today by some alternative doctors of medicine, osteopathy, dentistry, psychology and naturopathy, as well as chiropractors, for analysis, treatment, and nutritional recommendations. This procedure is experimental in nature. While there has been peer review research and publications of Applied Kinesiology in professional journals, some of the techniques have not been supported, and results were inconsistent as measured using standard scientific methods.

Dr. Janet McKush with Thrive Healing Arts Center L.L.C. is certified in Applied Kinesiology. I agree to the above testing procedures and to treatment as agreed upon by the doctor and myself. I am willing to take responsibility for and reserve the right to accept or reject any recommendations related to muscle testing.

Nutrition

I understand that according to the federal Food, Drug, and Cosmetic Act, Section 201 (g)(1), the term 'Drug' is defined to mean: "Articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease". I understand that a vitamin is not a drug, neither is a mineral, trace element, amino acid, herb, or homeopathic remedy. Although these may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug.

I understand that dietary or nutritional advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, dietary advice, and vitamin recommendations are provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition to support the biochemical processes of the body. Nutritional recommendations may also enhance the stabilization of chiropractic adjustments and treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Name (Print):_____Date:_____

Patient Signature:_____Date:_____
(If patient is a minor, signature of parent / guardian)

Provider Signature:_____Date:_____

Patient Health Information Consent Form

We want you to know how your Patient health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you have read and understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at our front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the health insurance company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known in this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations or these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of patient Date