

903 S. Friendswood Dr.  Friendswood, TX 77546  281.612.2116

**YIN & YANG Healthcare**  
**CONFIDENTIAL PATIENT INFORMATION**

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

**How did you hear about us?**  Google / FB / yelp  Insurance  Location  Zocdoc  
 Referred by \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **TX** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

Important:

Free e-newsletter will be sent at this email address regarding alternative medicine and health tips, etc.

**Phone (cell):** \_\_\_\_\_ **(home):** \_\_\_\_\_ **(work):** \_\_\_\_\_

**Name of spouse / parent:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Whom may we contact in case of emergencies? Name:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICES.**

I hereby authorize \_\_\_\_\_ and **YIN & YANG Healthcare LLC** to release my personal and medical information to my insurance company, adjustor or attorney should it be necessary. I further authorize and direct the health / accident insurance company and/or the attorney, to pay directly to \_\_\_\_\_ and **YIN & YANG Healthcare LLC**, for professional services rendered me. This is to act as an **assignment of the rights and benefits** to the extent of all services provided. I also understand that if I suspend or terminate my care and treatment, any fees for all services rendered me will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance.

**Patient / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Application for Treatment: History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

What is your complaint? Where? \_\_\_\_\_

How did it begin? After a sleep / fall / drive / flight / lifting / over-reaching / sitting / housework / chronic illness \_\_\_\_\_ Type? acute / chronic / recurring / sub-acute

When date was this condition first noticed? \_\_\_\_\_

What is quality of discomfort? Frequency?

aching / sore / annoying / burning / deep / diffuse / dull / heavy / pulling / sharp / shock / stabbing / stiffness / throbbing / tightness / tingling / numbness

25%  Intermittent    50%  Occasional    75%  Frequent    100%  Constant

Is the discomfort going down to the arms or legs? Yes / No and Where? \_\_\_\_\_

How is this condition progressing?  Worse  Better  Same

What is the VAS?            0 1 2 3 4 5 6 7 8 9 10 (Excruciating)

Condition relived by? \_\_\_\_\_ or nothing

It aggravated by? \_\_\_\_\_ or almost any movement

Any past episodes of this complaint? \_\_\_\_\_

Have you seen any other practitioners for this condition? MD / DC / PT / LAc

If yes, name, type, and dates seen: \_\_\_\_\_

What did they recommend? \_\_\_\_\_

Have any recent diagnostic images or tests been performed? \_\_\_\_\_

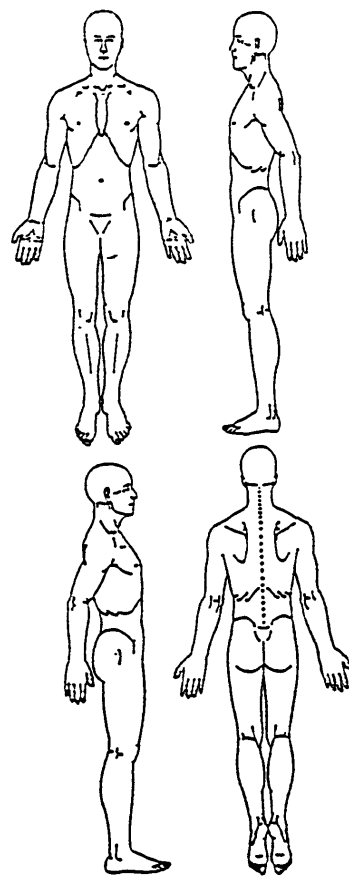
What do you have difficulty performing due to this complaint? \_\_\_\_\_

What are your specific therapeutic goals? \_\_\_\_\_

What Activity of Daily Living was most affected?

working / homemaking / social life / personal care (washing, dressing, etc.) / sleeping / sitting / standing / walking / driving

Mark Affected Areas below:



List all auto accidents and/or Major Traumas:  Past year  Past 5 years  Over 5 years  Never

Please describe: \_\_\_\_\_

If Injury or Accident Please complete these questions: Date injured: \_\_\_\_\_ Time: \_\_\_\_\_

Have you lost any days of work? \_\_\_\_\_ Dates: \_\_\_\_\_

Please describe how your accident happened: \_\_\_\_\_

Company of person responsible for injuries: \_\_\_\_\_

Attorney's name (if applicable): \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Auto Accident Only: You were  Driver  Passenger  Pedestrian, In a  Car  Truck  Other \_\_\_\_\_

Your vehicle:  Struck the other(s)  Was struck by the other(s)  Undetermined

Approximate size and speed of your car \_\_\_\_\_ = \_\_\_\_\_ M/H, Other car \_\_\_\_\_ = \_\_\_\_\_ M/H

Part of your vehicle hit:  Back  Front  Right side  Left side  Other \_\_\_\_\_

You were wearing:  Seatbelt  Shoulder harness  Airbag deployed. Were the police noticed? Yes / No

Did you brace for impact? Yes/No. You were looking:  Forward  Left  Right Did head hit headrest? Yes/No.

Did you strike the interior of the vehicle? Yes/No. With what part of your body? \_\_\_\_\_

Did you lose consciousness at any point? Yes/No, Were you treated by medical personnel for injuries? Yes/No

# CONFIDENTIAL PATIENT INFORMATION

Please fill in all portions of this form. If you need help, please ask.

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

Reason(s) for Visit \_\_\_\_\_

## Current Symptoms: Please check all that apply

<p><b>FEVER and CHILLS</b></p> <input type="checkbox"/> Aversion to Cold <input type="checkbox"/> Heat <input type="checkbox"/> Aversion to Wind <input type="checkbox"/> Fever and Chills Alternately <input type="checkbox"/> Fever and Chills Simultaneously <input type="checkbox"/> High <input type="checkbox"/> Low Fever <input type="checkbox"/> Fever Intermittently <input type="checkbox"/> Night Fever <p><b>PERSPIRATION</b></p> <input type="checkbox"/> No Sweating <input type="checkbox"/> Profuse Sweating <input type="checkbox"/> Spontaneous Sweating <input type="checkbox"/> Sweating at Night <input type="checkbox"/> Sweating in the Palm <p><b>SKIN</b></p> <input type="checkbox"/> Bruising Easily <input type="checkbox"/> Change in Moles <input type="checkbox"/> Dry Skin / Itching <input type="checkbox"/> Rash / Sensitive Skin <input type="checkbox"/> Sores that Won't Heal <p><b>NEUROLOGICAL</b></p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Panic <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty Concentrating <input type="checkbox"/> Dizziness <input type="checkbox"/> Epilepsy / Seizures <input type="checkbox"/> Irritability <input type="checkbox"/> Memory Loss <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Weak Muscles	<p><b>HEAD/EYE/ENT</b></p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Cataracts <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Headache <input type="checkbox"/> Migraine <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Loss of Taste <input type="checkbox"/> Smell <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Post Nasal Drip <input type="checkbox"/> Runny Nose <input type="checkbox"/> Sore Throat <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> TMJ Problems <p><b>MUSCULOSKELETAL</b></p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Ankle Pain <input type="checkbox"/> Back Problems <input type="checkbox"/> Elbow Pain <input type="checkbox"/> Heel <input type="checkbox"/> Foot Pain <input type="checkbox"/> Hip <input type="checkbox"/> Pelvis Problems <input type="checkbox"/> Knee Pain <input type="checkbox"/> Lack of Coordination <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder Pain <input type="checkbox"/> Poor Posture <input type="checkbox"/> Scoliosis <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Wrist <input type="checkbox"/> Hand Pain	<p><b>GASTRO-INTESTINE</b></p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Bloating <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficult Swallowing <input type="checkbox"/> Eating Disorders <input type="checkbox"/> Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> IBS <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach Pain <p><b>HEART/LUNGS</b></p> <input type="checkbox"/> Apnea <input type="checkbox"/> Chest Pain or tightness <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Emphysema <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Lower extremity edema <input type="checkbox"/> Pneumonia <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Snoring Issues <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Varicose Veins	<p><b>MALE ONLY</b></p> <input type="checkbox"/> Discharge from Penis <input type="checkbox"/> Erection Difficulties <input type="checkbox"/> Lump in Testicle <input type="checkbox"/> Sore on Penis <p><b>FEMALE ONLY</b></p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between Periods <input type="checkbox"/> Breast Lump <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> PMS <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Vaginal Dryness <p><b>ENDOCRINE</b></p> <input type="checkbox"/> Cold Hands and Feet <input type="checkbox"/> Heat <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> High Blood Sugar <input type="checkbox"/> Hyper <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteopenia <input type="checkbox"/> Rheumatism <input type="checkbox"/> Steroid Treatments <input type="checkbox"/> Testosterone deficiency <p><b>URINARY</b></p> <input type="checkbox"/> Bloody Urine <input type="checkbox"/> Dribbling <input type="checkbox"/> Kidney Stone <input type="checkbox"/> Frequent Infections <input type="checkbox"/> Painful / Frequent Urination <input type="checkbox"/> Lack of Bladder Control
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<p><b>MEDICATIONS / VITAMINS / SUPPLEMENTS</b> Please List all medications and dosages</p> <input type="checkbox"/> Pain Killers _____ <input type="checkbox"/> Muscle Relaxers _____ <input type="checkbox"/> Blood Pressure _____ <input type="checkbox"/> Birth Control Pills _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Herbs _____ <input type="checkbox"/> Vitamins _____ <input type="checkbox"/> Supplements _____ <input type="checkbox"/> Others _____	<p><b>ALLERGIES</b> Please List:</p> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<p><b>HEALTH HABITS</b> Please check which substances you use and list how much:</p> <input type="checkbox"/> Coffee: _____ <input type="checkbox"/> Tobacco: _____ <input type="checkbox"/> Alcohol: _____ <input type="checkbox"/> Drugs: _____ <input type="checkbox"/> Other: _____
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Did you have any **transmitted diseases**?  COVID-19  AIDS  Hepatitis  Other(s): \_\_\_\_\_

**PAST or CURRENT ADDITIONAL CONDITIONS**

Please check (✓) any conditions you have had.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Prostate Problems  |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> COVID-19             | <input type="checkbox"/> HIV Positive       | <input type="checkbox"/> Psoriasis/Eczema   |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Psychiatric Care   |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Leg Cramps         | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Sinusitis          |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Measles            | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Goiter               | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Gonorrhea            | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Herpes               | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal Disease   |

**FAMILY HISTORY**

Relation:	<u>Father</u>	<u>Mother</u>	<u>Sibling 1</u>	<u>Sibling 2</u>	<u>Child 1</u>	<u>Child 2</u>
Age if living:						
Age at Death:						
Cause of Death:						
	Please check if any of the following conditions applied to the above relatives:					
Immune Disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Stroke:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HOSPITALIZATIONS, SURGERIES AND MAJOR ILLNESSES**

Year	Condition or Procedure	Outcome
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____

**PREGNANCY HISTORY**

Number of Pregnancies: \_\_\_\_\_  
 Number of Live Births: \_\_\_\_\_  
 Check if you've had any of the following:  
 Abortion  Miscarriage  Premie

**MENSTRUATION**

Last Menstrual Period: \_\_\_\_\_  
 Last Pap Smear: \_\_\_\_\_  
 Have you had a Mammogram? \_\_\_\_\_  
 Check if you've had any of the following:  
 No periods  Delayed  Early  Irregular  
 Painful periods  PMS  
 Scanty periods  Heavy periods  
 Brown Red  Dark Red  Excessive clots

**SLEEPING PATTERN**

How many hours per night? \_\_\_\_\_  
 Please check if you have any of the following:  
 Frequent Waking  Nightmares  Snoring  
 Nap during day  Sleep walk  Grind Teeth

**OCCUPATION**

Check if you are exposed to:  Stress  
 Heavy Lifting  Hazardous Substances

**EXERCISE**

How often do you exercise? \_\_\_\_\_  
 What type? \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

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

**PATIENT RECORD, IMAGE AND VOICE OF DISCLOSURES**

In general, the HIPPA privacy rule gives patients the right to request a restriction on the uses and disclosures of their protected health information (PHI). The individual is also given the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's residence. We would like to respect those rights in every way possible and request that you fill in the following:

**I wish to be contacted in the following manner (check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work address |
|--|--|
- Email: \_\_\_\_\_

Date	Disclosed to Whom Address/Fax	(1)	Description of Disclosure Purpose of Disclosure	By Whom Disclosed	(2)	(3)

- (1) Check this box if Disclosure is authorized  
 (2) Type Key: T= Treatment Records P= Payment Information O= Healthcare Operations  
 (3) Enter how disclosure was made: F=Fax; P= Phone ; E= Email; M= Mail; O= Other

I hereby voluntarily and without compensation, authorize images and/or voice recording(s) to be made of me by YIN & YANG Healthcare LLC and \_\_\_\_\_.

I understand that said images and/or voice recordings are intended for use of legitimate business or educational purposes for the clients' organization. Such purposes include but are not limited to, internal and external educational purposes, promotional materials, training and advertisements.

I have read and understand the foregoing and I consent to the use of my image and/or voice as specified for the above named purpose(s). I further understand that no royalty, fee or other compensation of any kind shall become payable to me for the use of my image and/or voice.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birthday

Privacy regulations generally require healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided above, if completed properly, will constitute an adequate record.

**Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

# Informed Consent to Chiropractic and Acupuncture Treatment

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

**The nature of acupuncture treatment:** The doctor may also use acupuncture as an adjunct, or in whole, during your care. Acupuncture involves the insertion of tiny needles into the body through the skin. It may also involve the use of pressure, electrical stimulation.

**Possible Risks:** As with any health care procedure, complications are possible following a **chiropractic manipulation**. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary sore, pressure, numb, burning or tingling sensation at the acupuncture site and even radiating to certain regions of the body. There have been rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. **Chinese herbs** that have been recommended are traditionally considered safe in the practice of traditional Chinese medicine. Some herbs may be inappropriate during pregnancy. If any gastrointestinal upset or allergic reactions are experienced with the herbs, discontinue immediately and consult your doctor.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”. The probability of adverse reaction due to acupuncture and Chinese herbs are also considered “rare”. They would be significantly less than the chance of adverse complication due to prescription medication use, medication injection or surgery.

**Other treatment options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual risks:** I have had any unusual risks of my case explained to me. I have read the explanation above of chiropractic and acupuncture treatments. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatments and understand that no guarantees of outcome have been made. I have freely decided to undergo the recommended treatments and hereby give my full consent to treatments.

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Signature**

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

**WITNESS:**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Signature**

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