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4606 Cypress Creek Pkwy STE. 412

Houston, TX 77069

**Confidential Client Intake Information**

The information provided on this form will be kept confidential and will be helpful in planning counseling services for you. Please answer each item to the best of your ability. All information is held in strictest confidence. (**Please print clearly**.)

**GENERAL INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name you prefer to be called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: □ M □ F

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to contact you? □ Home Phone □ Work Phone □ Cell Phone □ E-mail\* (**Please check all that apply)**

*\*Please be aware that the confidentiality of e-mail cannot be guaranteed due to the nature of electronic media. However, all correspondence by e-mail will be treated as private and confidential in the UTEAP/Counseling office.*

Legal Guardian / Parent (if under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(****PRINT*** *Name of Legal Guardian / Parent and address if different from above)*

 Who does the child / minor live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Relationship)*

*(Name)*

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

Are you a veteran of the U.S. Armed Forces? □ Yes □ No Are you currently an active reservist? □ Yes □ No

Are you living with or in a significant relationship with a veteran or active duty reservist? □ Yes □ No

Religious / denominational preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Racial / Ethnic Identity: □ African American / Black □ Asian or Pacific Islander □ American Indian □ Alaskan Native □ Caucasian / White □ Hispanic / Latino □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Medical Insurance: □ Blue Cross/Blue Shield □ United Health □ Humana □ Medicaid / Medicare □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Relationship)*

*(Name)*

Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATUS FOR ELIGIBILITY OF SERVICES**

Please check the appropriate designation(s) and provide the requested information.

□ EMPLOYEE- please provide the name of the Company/Department/Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ DEPENDENT- please indicate the name of the employee and their relationship to you.

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

*(****PRINT-****Name)*

*(Relationship)*

**FAMILY / RELATIONSHIP INFORMATION**

Relationship Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed □ Cohabitating

Parents: **Mother**: □ Living □ Deceased **Father**: □ Living □ Deceased

 Age: \_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_

Siblings: Number of Brothers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Sisters: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 List ages of Brothers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ List ages of Sisters: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names and ages of your children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any of your children passed away? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESENTING PROBLEM / CONCERN(S)**

Briefly describe your reasons for seeking counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has this been a problem or concern for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Does Not Apply | Not at All |  |  |  | Very Much |
| Job/School Performance | □ | 1 | 2 | 3 | 4 | 5 |
| Marriage/Partner | □ | 1 | 2 | 3 | 4 | 5 |
| Family | □ | 1 | 2 | 3 | 4 | 5 |
| Friendships | □ | 1 | 2 | 3 | 4 | 5 |
| Legal Situation | □ | 1 | 2 | 3 | 4 | 5 |
| Health | □ | 1 | 2 | 3 | 4 | 5 |
| Child Rearing | □ | 1 | 2 | 3 | 4 | 5 |
| Ability to Control Temper | □ | 1 | 2 | 3 | 4 | 5 |
| Spirituality | □ | 1 | 2 | 3 | 4 | 5 |

How has this problem affected your:

**Please answer the next three questions:**

1. How severe do you consider your present problem / concerns?

□ Not Severe □ Somewhat Severe □ Moderately Severe □ Very Severe

1. How motivated are you to resolve your problem / concerns?

□ Mildly Motivated □ Somewhat Motivated □ Moderately Motivated □ Very Motivated

1. How optimistic are you that your problem / concerns can be resolved?

□ Mildly Optimistic □ Somewhat Optimistic □ Moderately Optimistic □ Very Optimistic

**Place a ☑ by any of these statements that are true for you:**

□ I have thoughts of harming myself or others.

 □ Thoughts of harming myself or others is a frequent occurrence.

 □ I dwell on thoughts of harming myself or others.

 □ I have attempted suicide. Approximate date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Means: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ I have attempted to harm someone else. Approximate date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Means: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ None of the statements listed about harming myself or others is true for me.

**Are any of the following conditions a problem for you at this time? (*Check all that apply*)**

* + - Anxiety □ Self-esteem □ Relationship with Parents
		- Grief □ Stress □ Relationship with Children
		- Depression □ Substance Abuse □ Relationship with Spouse / Partner
		- Irrational Fears □ Chronic Fear □ Relationship with Staff / Co-workers
		- Nervousness □ Guilty Feelings □ Relationship with Friends / Peers
		- Loneliness □ Cutting / Self Harm □ Anger / Rage
		- Loss of Hope □ Sexual Issues □ Medical / Health Concerns
		- Conflicts at work □ Test Anxiety □ Sleep Difficulties
		- Loss of work / job □ Financial Spending □ Preoccupation with Another Person
		- Compulsive Behavior □ Gambling Issues □ Preoccupation with Sex
		- Eating / Body Image □ Procrastination □ Preoccupation with Video Games
		- Physical Abuse or Assault □ Legal Concerns □ Obsessive thoughts
		- Religious / Spirituality Issues □ Internet Concerns □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUBSTANCE USE: IMPACT OF SUBSTANCE / ALCOHOL USE**

**Alcohol Frequency** □ Never □ Less than 1 time / month □ 1-4 times / month □ 2-3 times / week □ Daily

**Alcohol Consumption** □ None □ 1-2 drinks per sitting □ 3-4 drinks per sitting □ 5 or more drinks per sitting

**Drug Use** □ None □ Marijuana □ Cocaine □ Anti-Depressants □ Stimulants □ Opiates □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Frequency** □ Never □ Less than 1 time / month □ 1-4 times / month □2-3 times / month □ Daily

**Please check all that apply:**

* Have you felt the need to cut down on your drinking / drug use?
* Do you feel annoyed by people complaining about your drinking / drug use?
* Do you ever feel guilty about your drinking / drug use?
* Do you ever drink an ‘eye-opener’ in the morning to relieve shakes?

**BRIEF FAMILY HISTORY**

**Please check all that apply**

□ Drug Usage □ Alcohol Abuse □ Suicide / Suicide Attempt □ Depression □ Anxiety □ Bipolar Disorder

Who in the family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Relationship to you*)

**MEDICAL HISTORY**

Name and telephone number of your physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last medical examination? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you experiencing any physical illnesses or symptoms at this time? □ No □ Yes (**please explain**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you had a head injury or been diagnosed with a concussion? If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

List major surgeries or illnesses in the last five years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list ALL medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed by any physician or taken over the counter):

 Name of Medication Dosage / Frequency Purpose / Medical Condition

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

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

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

**What is your daily caffeine intake**? □ Never or infrequently □ 12-24 oz. (1-2 servings) □ 25-60 oz. (3-5 servings) □ 60+ oz. (5+ servings)

**PSYCHOLOGICAL HISTORY**

Name and telephone number of your psychiatrist, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received psychotherapy / counseling, psychiatric hospitalization, and / or chemical dependency treatment in the past? □ No □ Yes (***please provide as much information as possible below***)

 When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for Counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for Hospitalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list at least one goal that you would like to accomplish with counseling:** ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_ I confirm that I have read, understood and fully reported to the best of my ability all information requested on this form.

**(*Initial*)**

**Thank you for providing the information requested. Please sign and date below.**

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

***Date***

***Printed Name***

***Client Signature***

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

 ***Clinician Signature Printed Name Date***