

Dr. **Sandra Miranda BSc, ND**

*Doctor of Naturopathic Medicine*

Dear Patient:

Thank you for choosing the Miranda Naturopathic Clinic for your Health Care Needs. By choosing our clinic, we assure you that you are choosing the highest quality of health care. In order to best help you, we will need to know about your medical history. Please take a few moments to fill in the following questionnaire and the enclosed diet diary before your next appointment.

Your first appointment will take approximately 1 hour. Follow up visits are 30 – 45 minutes depending upon how much time the Doctor needs to spend with you. During the first visit, an in-depth health history is taken in order to understand all factors that may be affecting you. The visit also includes a health oriented physical exam, urinalysis and a body composition test. Further laboratory testing may be discussed and performed if indicated. All this information will assist us to make a thorough assessment of your condition. All information will remain completely confidential. A personalized treatment plan will then be proposed.

If possible, please arrange, bring, mail or fax all medical test (blood, urine, ultrasound, MRI’s and surgery results) pertaining to your health from your physician’s office.

As a courtesy to our patients with allergies and for your possible homeopathic treatment, we ask that you do not wear perfume of any kind in the clinic.

Please remember that it takes time to feel better when using naturopathic medicine. You may be a patient who has spent many years with a chronic medical problem unsolved by conventional medicine; or you may be feeling well and want to make adjustments in order to improve your general health. No matter what your reasons are for coming, remember that some patients need to be patient! The more you are able to participate in your own care, the easier it will be to address your health concerns.

1. This is to acknowledge that I have read the above information and understood its contents.
2. I agree to pay my full account at the time of each visit or treatment, including fees for services, laboratory tests or any supplement or remedies I may wish to purchase.
3. I authorize and consent to the treatments I may receive from Miranda Naturopathic Clinic of my own free will and choice.
4. I understand that I am at liberty to seek or continue medical care from a physician or health care provider.
5. I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating my intentions first.

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Patient’s Signature Date

Thank you for taking the time and patience to complete this form. We know it is very detailed but it is very important to collect all the details to know “the whole person” and in finding the root cause of your problem. We look forward to working with you and your family in your Naturopathic care.

# INTAKE FORM

### PERSONAL DATA

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred name/nickname: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_ P/C: \_\_\_\_\_\_\_\_\_

Phone: H – (\_\_\_\_) \_\_\_\_-\_\_\_\_\_ W – (\_\_\_) \_\_\_\_ - \_\_\_\_\_\_ Ext: \_\_\_\_ Where can we leave a message? H W

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: (mm/dd/yyyy) \_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Sex: F / M

How did you hear about our clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive weekly health tips from Miranda Naturopathic Clinic?: Y N

**Other Health Care Providers**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

#### Emergency contact: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_

##### CHIEF HEALTH CONCERNS

Indicate your main health concern(s) – In order of importance to you. For how long have you had this problem?

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### HEALTH STATUS

Current weight: \_\_\_\_\_\_\_\_\_\_\_ Ideal Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Maximum Weight: \_\_\_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_\_\_\_

What do you usually eat and drink for:

Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beverages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many antibiotic treatments have you received? 0 – 5 times 6 – 13 times more than 13 times

List any medications/supplements that you have taken or are currently taking. (P = past / C = current)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Starting Age | P/C | Medication/Supplement | Illness | Adverse Reactions |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

SOCIAL ENVIRONMENT

How often do you do the following?:

Smoke Cigarettes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drink Coffee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drink Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drink Water \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Use Recreational Drugs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Which one(s): \_\_\_\_\_\_\_\_\_\_\_\_

Indicate the emotional climate of your home: Very stable Stable Stressful Very Stressful

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate if any of the members living in your household smoke: Yes/No

How many hours per week do you exercise? None 1 – 3 hrs 4 – 6 hrs more than 6 hours

How many hours of sleep, on average, do you get each night? Less than 6 6 – 8 hrs more than 8 hrs

How many hours do you work per week? None 1 – 8 hrs 8 –16 hrs more than 16 hours

If sexually active, please answer the following two questions:

Form of contraceptions used:

Birth Control Pill Condom Diaphragm IUD Sponge Cervical Cap Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate if you have or have had any sexually transmitted diseases:

Gonorrhea Chlamydia HIV Human Papillomavirus Hepatitis B Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### FAMILY HEALTH HISTORY

Indicate if anyone in your family has had any of the following health problems:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Health Problem | Relationship to the patient | Age of onset | For how long | Cause of death (if applicable) |
| Hypertension |  |  |  |  |
|  |  |  |  |  |
| Cancer |  |  |  |  |
|  |  |  |  |  |
| Diabetes |  |  |  |  |
|  |  |  |  |  |
| Asthma |  |  |  |  |
|  |  |  |  |  |
| Allergies |  |  |  |  |
|  |  |  |  |  |
| Heart Problems |  |  |  |  |
|  |  |  |  |  |
| Other |  |  |  |  |
|  |  |  |  |  |

REVIEW OF SYSTEMS

If you have had any of the conditions below, please circle “P” for past and “C” for current.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SKIN | | |  | EYES | |
| Acne, boils | | Yes (P/C) No |  | Blind spots | Yes (P/C) No |
| Psoriasis | | Yes (P/C) No |  | Cataracts | Yes (P/C) No |
| Eczema/hives | | Yes (P/C) No |  | Redness | Yes (P/C) No |
| Excessive dryness | | Yes (P/C) No |  | Double vision | Yes (P/C) No |
| Itching | | Yes (P/C) No |  | Excessive tearing | Yes (P/C) No |
| Rashes | | Yes (P/C) No |  | Eye infections | Yes (P/C) No |
| Tendency to bruise | | Yes (P/C) No |  | Eye pain | Yes (P/C) No |
| Change in moles | | Yes (P/C) No |  | Impaired vision | Yes (P/C) No |
| Colour changes | | Yes (P/C) No |  | Itching | Yes (P/C) No |
| Nail/Hair changes | | Yes (P/C) No |  |
| Night sweats | | Yes (P/C) No |  |  |  |
| **MOUTH AND THROAT** | | | | **HEAD** | |
| Dental cavities | | Yes (P/C) No |  | Dizziness | Yes (P/C) No |
| Frequent bad breath | | Yes (P/C) No |  | Head lice | Yes (P/C) No |
| Frequent sore throat | | Yes (P/C) No |  | Headache | Yes (P/C) No |
| Gum bleeding | | Yes (P/C) No |  | Injury | Yes (P/C) No |
| Hoarseness | | Yes (P/C) No |  | Meningitis Yes (P/C) No | |
| Loss of taste | | Yes (P/C) No |  |  | |
| Toothaches | | Yes (P/C) No |  | NECK | |
| Sore tongue | | Yes (P/C) No |  | Difficult in holding head | Yes (P/C) No |
| Thrush | | Yes (P/C) No |  | Limitation of movement | Yes (P/C) No |
| Times patient brushes daily | |  |  | Lumps | Yes (P/C) No |
| Last visit to dentist | |  |  | Pain or stiffness | Yes (P/C) No |
|  | |  |  | Thyroid enlargement | Yes (P/C) No |
|  | |  |  |  |  |
| **EARS** | | |  | NOSE AND SINUSES | |
| Discharge | | Yes (P/C) No |  | Frequent colds | Yes (P/C) No |
| Dizziness | | Yes (P/C) No |  | Hay fever | Yes (P/C) No |
| Earache | | Yes (P/C) No |  | Loss of sense of smell | Yes (P/C) No |
| Impaired hearing | | Yes (P/C) No |  | Nose bleeds | Yes (P/C) No |
| Infections | | Yes (P/C) No |  | Sinus problems | Yes (P/C) No |
|  | |  |  | Stuffiness | Yes (P/C) No |
|  | |  |  |  |  |
| **GASTROINTESTINAL** | | |  | RESPIRATORY | |
| Abdominal Pain | | Yes (P/C) No |  | Asthma | Yes (P/C) No |
| Blood in stools | | Yes (P/C) No |  | Bronchitis | Yes (P/C) No |
| Change in bowel habits | | Yes (P/C) No |  | Frequent cough | Yes (P/C) No |
| Change in thirst | | Yes (P/C) No |  | Difficulty breathing | Yes (P/C) No |
| Change in appetite | | Yes (P/C) No |  | Frequent colds | Yes (P/C) No |
| Constipation | | Yes (P/C) No |  | Pain on breathing | Yes (P/C) No |
| Decreased appetite | | Yes (P/C) No |  | Pneumonia | Yes (P/C) No |
| Diarrhea | | Yes (P/C) No |  | Mononucleosis | Yes (P/C) No |
| Flatulence/passing gas | | Yes (P/C) No |  | Shortness of breath at rest | Yes (P/C) No |
| Food intolerance | | Yes (P/C) No |  | Spitting up blood | Yes (P/C) No |
| Food allergy | | Yes (P/C) No |  | Sputum production | Yes (P/C) No |
| Hemias | | Yes (P/C) No |  | Tuberculosis | Yes (P/C) No |
| Increased appetite | | Yes (P/C) No |  | Wheezing | Yes (P/C) No |
| Indigestion | | Yes (P/C) No |  | Last tuberculin test |  |
| Jaundice | | Yes (P/C) No |  | Date of last X-ray |  |
| Liver disease | | Yes (P/C) No |  |  |  |
| Nausea | | Yes (P/C) No |  | PERIPHERAL |  |
| Trouble swallowing | | Yes (P/C) No |  | Deep leg pain | Yes (P/C) No |
| Vomiting | | Yes (P/C) No |  | Cold hand/feet | Yes (P/C) No |
| Vomiting blood | | Yes (P/C) No |  | Varicose veins | Yes (P/C) No |
| Obesity | | Yes (P/C) No |  | Leg cramps | Yes (P/C) No |
| Anorexia Nervosa | | Yes (P/C) No |  | Extremity numbness | Yes (P/C) No |
| Bulimia | | Yes (P/C) No |  | Extremity coldness | Yes (P/C) No |
| Bowel movts, how often | |  |  | Extremity ulcers | Yes (P/C) No |
|  | |  |  |  |  |
| **CARDIOVASCULAR** | | |  | URINARY | |
| Anaemia | | Yes (P/C) No |  | Blood in urine | Yes (P/C) No |
| Chest pain/discomfort | | Yes (P/C) No |  | Change in size of scrotum | Yes (P/C) No |
| Congenital heart problems | | Yes (P/C) No |  | Frequency at nights | Yes (P/C) No |
| Cyanosis | | Yes (P/C) No |  | Hesitancy | Yes (P/C) No |
| Fatigue on exertion | | Yes (P/C) No |  | Increased frequency | Yes (P/C) No |
| Heart murmur | | Yes (P/C) No |  | Kidney stones | Yes (P/C) No |
| Palpitation/fluttering | | Yes (P/C) No |  | Pain on urination | Yes (P/C) No |
| Recent transfusion | | Yes (P/C) No |  | Polyuria | Yes (P/C) No |
| Rheumatic fever | | Yes (P/C) No |  | Unpleasant odour of urine | Yes (P/C) No |
| Hypertension | | Yes (P/C) No |  | Urgency/Inability to hold | Yes (P/C) No |
| Blood type | |  |  | Date of last urinalysis |  |
| Date of last blood test | |  |  | Urination, how often? |  |
|  | |  |  |  |  |
| **FEMALE REPRODUCTIVE** | | |  | MALE REPRODUCTIVE | |
| Breast tenderness | | Yes (P/C) No |  | Discharge or sores | Yes (P/C) No |
| Nipple discharge | | Yes (P/C) No |  | Testicular pain | Yes (P/C) No |
| Vaginitis | | Yes (P/C) No |  | Testicular masses | Yes (P/C) No |
| Vaginal discharge | | Yes (P/C) No |  | Breast enlargement | Yes (P/C) No |
| Vaginal itching | | Yes (P/C) No |  | Hernias | Yes (P/C) No |
| Endometriosis | | Yes (P/C) No |  | Wet dreams | Yes (P/C) No |
| Age menses began | |  |  | Varicocele | Yes (P/C) No |
| Are cycles regular? | | Yes (P/C) No |  | Age that voice began to deepen |  |
| Length of cycle | |  |  | Age that facial hair first appeared |  |
| Excessive flow | | Yes (P/C) No |  | Do you need a genital exam? | Yes/No |
| Average number of days | |  |  |  | Initials: \_\_\_\_\_\_\_\_ |
| Bleeding between periods | | Yes (P/C) No |  | Do you need a prostate exam? | Yes/No |
| Painful menses | | Yes (P/C) No |  |  | Initials: \_\_\_\_\_\_\_\_ |
| PMS | | Yes (P/C) No |  |  |  |
| Last menstrual period | |  |  |  |  |
| Pregnancy, how many | |  |  |  |  |
| Abortions, how many | |  |  |  |  |
| Do you need a breast eeEeeeeeeeeeeEEExaaexam? | | Yes/No |  |  |  |
| Exam | | Initials: \_\_\_\_\_\_\_\_ |  |  |  |
| Do you need an internal exam? | | Yes/No |  |  |  |
| Exam | | Initials: \_\_\_\_\_\_\_\_ |  |  |  |
|  | |  |  |  |  |
| MUSCULOSKETETAL | | |  | NEUROLOGIC | |
| Abnormal gait | Yes (P/C) No | |  | Dizziness | Yes (P/C) No |
| Arthritis | Yes (P/C) No | |  | Fainting | Yes (P/C) No |
| Back or joint stiffness | Yes (P/C) No | |  | Involuntary movements | Yes (P/C) No |
| Backaches | Yes (P/C) No | |  | Loss of memory | Yes (P/C) No |
| Broken bones | Yes (P/C) No | |  | Loss of balance | Yes (P/C) No |
| Clumsiness | Yes (P/C) No | |  | Muscle weakness | Yes (P/C) No |
| Deformity | Yes (P/C) No | |  | Nightmares | Yes (P/C) No |
| Fractures | Yes (P/C) No | |  | Numbness or tingling | Yes (P/C) No |
| Joint swelling | Yes (P/C) No | |  | Paralysis | Yes (P/C) No |
| Lack of co-ordination | Yes (P/C) No | |  | Seizure/Convulsions | Yes (P/C) No |
| Muscle pains or cramps | Yes (P/C) No | |  | Speech problems | Yes (P/C) No |
| Serious sprains | Yes (P/C) No | |  | Tremors | Yes (P/C) No |
| Weakness | Yes (P/C) No | |  | Nervous | Yes (P/C) No |
| Short stature | Yes (P/C) No | |  |  |  |
| Tall stature | Yes (P/C) No | |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ENDOCRINE** | |  | EMOTIONAL | |
| Diabetes | Yes (P/C) No |  | Panic attacks | Yes (P/C) No |
| Excessive thirst | Yes (P/C) No |  | Rage reactions | Yes (P/C) No |
| Excessive urination | Yes (P/C) No |  | Fatigue | Yes (P/C) No |
| Excessive sweating | Yes (P/C) No |  | Anxiety or nervousness | Yes (P/C) No |
| Excessive hunger | Yes (P/C) No |  | Depression | Yes (P/C) No |
| Growth hormone therapy | Yes (P/C) No |  | Mood swings | Yes (P/C) No |
| Hypoglycemia | Yes (P/C) No |  | Phobias/fears | Yes (P/C) No |
| Heat / cold intolerance | Yes (P/C) No |  | Insomnia | Yes (P/C) No |
| Salty taste to skin | Yes (P/C) No |  | History of child abuse | Yes (P/C) No |
| Signs of early puberty | Yes (P/C) No |  | Suicidal thoughts | Yes (P/C) No |

# What else would you like me to know about your health?

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

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# THANK YOU FOR TAKING THE TIME TO FILL OUT THIS INTAKE FORM!