**Xu Wellness Center**

235 Germantown Bend Cove

Cordova, TN 38018

Phone: (901) 737-8282

Fax: (901) 737-8239

[www.XuWellnessCenter.com](http://www.XuWellnessCenter.com)

**New Patient Form**

|  |  |
| --- | --- |
| Name | Date |
| Street Address | Sex |
| City State Zip | Date of Birth |
| Mobile Phone | Marital Status | Height | Weight |
| Mobile Provider | Work Phone |
| Home Phone | Maiden/ Former Name |
| Email | Primary Physician |
| Social Security Number | Driver’s License Number and State |
| Occupation | Employer |
| Referred by | Other Family Members Seen Here |

Emergency Contact Information:

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

 Name Relationship

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

 Mobile Phone Home Phone Work Phone

**Medical History**

Please list all health complaints/ concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you already seen a physician for these complaints/ concerns? Was there a diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list all surgeries and hospital stays; please include the date and procedure:

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

Please list all significant traumas (auto accidents, falls, broken bones) and dates:

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

Please list all significant childhood illnesses and/ or injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list ALL allergies, include food sensitivities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are you currently under another physician’s care? Why and who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medical conditions from which you suffer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check all symptoms that you experience on a regular basis:

Skin and Hair:

|  |  |  |
| --- | --- | --- |
| * Eczema
 | * Hair Loss
 | * Rashes
 |
| * Hives
 | * Pimples/ Acne
 | * Ulcerations
 |
| * Purpura
 | * Changes in Hair/ Skin
 | * Dandruff
 |
| * Itching
 | * Psoriasis
 | * Brittle Nails
 |
| * Warts
 | * Hives
 | * Shingles
 |
| * Dry Hair/ Skin
 | * Fungal Infections
 | * Pale Pallor
 |
| * Boils
 | * Painful Scars/ Wounds
 | * Other:
 |

Head/ E.E.N.T.

|  |  |  |
| --- | --- | --- |
| * Loss of Smell
 | * TMJ Pain
 | * Clicking in Jaw
 |
| * Poor Vision
 | * Dizziness
 | * Blurry/ Double Vision
 |
| * Concussions
 | * Nosebleeds
 | * Sore/ Dry Throat
 |
| * Migraines
 | * Glasses
 | * Sinus Problems
 |
| * Dry Mouth
 | * Night Blindness
 | * Nasal Congestion
 |
| * Teeth Grinding
 | * Paralysis
 | * Glaucoma (Eye Pressure)
 |
| * Sinus Infections
 | * Copious Saliva
 | * Eye Strain
 |
| * Ringing in Ears
 | * Teeth Problems
 | * Facial Pain
 |
| * Color Blindness
 | * Poor Hearing
 | * Sore/ Bleeding Gums
 |
| * Eye Pain
 | * Earaches
 | * Mouth/ Tongue Sores
 |
| * Cataract
 | * Loss of Balance
 | * Bad Taste in Mouth
 |
| * Spots in Eyes
 | * Mucus
 | * Dry Throat
 |
| * Watery Eyes
 | * Facial Tics
 | * Headaches
 |
| * Hoarse Throat
 | * Itchy Eyes
 | * Teeth Loss
 |
| * Excessive Sneezing
 | * Loss of Taste
 | * Teeth Pain
 |
| * Loss of Strength/ Feeling
 | * Bad Breath
 | * Dry Eyes
 |
| * Difficulty Swallowing
 | * Excessive Nasal Drip
 | * Sore Tongue
 |
| * Frequent Colds
 | * Other Neck/ Head Problems:
 |

Cardiovascular

|  |  |  |
| --- | --- | --- |
| * Chest Pains
 | * High Blood Pressure
 | * Low Blood Pressure
 |
| * Palpitations
 | * Blood Clots
 | * Leg Cramps
 |
| * Irregular Heart Beat
 | * Fainting Spells
 | * Swelling in Extremities
 |
| * Heart Attack
 | * Heart Disease
 | * Phlebitis
 |
| * Pressure/ Tightening in Chest
 | * Murmur
 | * Rapid Heart Beat
 |
| * Spider Veins
 | * Varicose Veins
 | * Mitral Valve Prolapse
 |
| * Pacemaker
 | * Skipped Heartbeats
 | * Blood Disorder
 |
| * High Cholesterol
 | * Raynaud’s Disease
 | * Other:
 |

Gastrointestinal

|  |  |  |
| --- | --- | --- |
| * Indigestion
 | * Nausea
 | * Pain/ Cramps
 |
| * Hemorrhoids
 | * Vomiting
 | * Bad Breath
 |
| * Rectal Pain
 | * Irregular BMs
 | * Gas
 |
| * Constipation
 | * Bloody Stools
 | * Recent Weight Loss/ Gain
 |
| * Belching
 | * Diarrhea
 | * Black Stools
 |
| * Laxative Use
 | * Enema Use
 | * IBS
 |
| * Rectal Itch
 | * Bloating
 | * Acid Reflux
 |
| * Slow Digestion
 | * Hiatal Hernia
 | * Gallbladder Problems
 |
| * Liver Problems
 | * Fecal Incontinence
 | * Stomachache
 |
| * Bitter Taste in Mouth
 | * Colitis
 | * Sweet Taste in Mouth
 |
| * Intestinal Parasites
 | * Ulcer
 | * Stomach Gurgling
 |
| Number of BMs Daily:  | * Other:
 |

Respiratory

|  |  |  |
| --- | --- | --- |
| * Asthma
 | * Bronchitis
 | * Difficulty Breathing While Lying Down
 |
| * Shortness of Breath
 | * Cough
 | * Shortness of Breath on Exertion
 |
| * Seasonal Allergies
 | * Excessive Phlegm
 | * Coughing Blood
 |
| * Emphysema
 | * Tight Chest
 | * Chronic Colds
 |
| * Tuberculosis
 | * Pleurisy
 | * Rheumatic Fever
 |
| * Pneumonia
 | * Dry Cough
 | * Wheezing/ Gasping
 |
| * Whooping Cough
 | * Sleep with Head Propped up
 | * Other:
 |

Endocrine

|  |  |  |
| --- | --- | --- |
| * Thyroid Cancer
 | * Hypoglycemia
 | * Adrenal Disorders
 |
| * Night Sweats
 | * Hypothyroidism
 | * Hyperthyroidism
 |
| * Metabolic Disorder
 | * Diabetes, type:
 | * Goiter
 |
| * Thyroiditis
 | * Thyroid Hormone Resistance
 | * Sex Hormone Disorders
 |
| * Glandular Tumor
 | * Other:
 |

Genitourinary

|  |  |  |
| --- | --- | --- |
| * Bladder Infections
 | * Urgency to Urinate
 | * Unable to Hold Urine
 |
| * Kidney Stones
 | * Dribble Urine while Sneezing/ Coughing
 | * Blood in Urine
 |
| * Painful Sex
 | * Wake up to Urinate
 | * Difficulty Starting Stream
 |
| * Burning/ Pain while Urinating
 | * STDs:
 | * Impotency
 |
| * Frequent Urination
 | * Kidney Infections
 | * Bladder Infections
 |
| * Infertility
 | * Cloudy Urine
 | * Wetting the Bed
 |
| * Weak Urine Stream
 | * Kidney/ Bladder Pain
 | * Bladder Reflux
 |
| * Frequent Urinary Tract Infections
 | * Other:
 |

Gynecological (Women Only)

|  |  |  |
| --- | --- | --- |
| * Vaginal Infections
 | * Breast Lumps
 | * Vaginal Discharge
 |
| * Clots
 | * Breast Discharge
 | * Vaginal Sores
 |
| * Vaginal Bleeding between Periods
 | * Vaginal Bleeding (Not with Menses)
 | * Painful Menses
 |
| * Fibroids
 | * Endometriosis
 | * Ovarian Cysts
 |
| * Vaginal Itching
 | * Yeast Infections
 | * Abortions:
 |
| * Irregular Menses
 | * Retain Water
 | * Breast Tenderness
 |
| * Increased Sex Drive
 | * Decreased Sex Drive
 | * PMS
 |
| * PID
 | * Changes in Body/ Psyche Prior to Menses
 | * Menopausal
 |
| * Gynecological Surgeries
 | * Hysterectomy
 | * Hot Flashes
 |
| * Hormone Replacement Therapy
 | * Recent Change in Menstrual Flow
 | * Sexually Active
 |
| * Gynecological Cancer
 | * Tubal Ligation
 | * Tubal Pregnancy
 |
| * Birth Control, type:
 |
| * Currently Pregnant, Month:
 | * Other:
 |
| * Premature Births:
 | * Miscarriages:
 |

Date of Last Period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration of Periods:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Pap:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Mammogram:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Pregnancies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Births:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your flow regular, heavy, or light, please explain if unusual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Men Only

|  |  |  |
| --- | --- | --- |
| * Prostate Cancer
 | * Hernia
 | * Nocturnal Emissions
 |
| * Enlarged Prostate
 | * Loss of Erection
 | * Prostatitis
 |
| * Genital/ Jock Itch
 | * Premature Ejaculation
 | * Pain in Testes/Penis
 |
| * Increased Sex Drive
 | * Decreased Sex Drive
 | * Low Sperm Count
 |
| * Groin Pain
 | * Testitis
 | * Hair Loss
 |
| * Testicular Cancer
 | * Penile Cancer
 | * Other:
 |

Musculoskeletal and Neurological

|  |  |  |
| --- | --- | --- |
| * Low Back Pain
 | * Neck Pain
 | * Muscle Pain
 |
| * Joint Pain
 | * Muscle Spasms/ Cramps
 | * Muscle Weakness
 |
| * Paralysis
 | * Poor Coordination
 | * Loss of Feeling
 |
| * Upper or Middle Back Pain
 | * Numbness/ Tingling:
 | * Pain Down Legs
 |
| * Degenerative Disease:
 | * Diseases/Disorders of the spine
 | * Brain Tumor
 |
| * Swollen Joints
 | * Bone Problems/ Pain
 | * Osteoporosis
 |
| * Vertigo
 | * Stroke
 | * Genetic Neurologic Disorder:
 |
| * Arthritis
 | * Disk Issues
 | * Fractures
 |
| * Joint Replacement
 | * Leg Cramps
 | * Chronic Pain:
 |
| * Acute Pain:
 | * Tremors
 | * Whiplash
 |
| * Torticollis
 | * Gout
 | * Stiff Neck
 |
| * Seizures
 | * Concussion
 | * Poor Memory
 |
| * Sprains/ Strains
 | * Noisy Joints
 | * Other:
 |

If you are experiencing pain, please describe frequency, duration, and location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychological/ Emotional/ Sleep

|  |  |  |
| --- | --- | --- |
| * Depression
 | * Bad Temper
 | * Mood Swings
 |
| * Wakens Easily
 | * Anxiety
 | * Easily Stressed
 |
| * Considered Suicide
 | * Attempted Suicide
 | * Unable to Fall Asleep
 |
| * Unable to Stay Asleep
 | * Feelings of Unhappiness
 | * Poor/Restless Sleep
 |
| * Insomnia
 | * Heavy Sleep
 | * Excessive Worry
 |
| * Easily Overwhelmed
 | * Excessive Fears
 | * Difficulty making Decisions
 |
| * Nightmares
 | * Obsessive Tendencies
 | * Inability to Focus
 |
| * Unmotivated
 | * Optimistic
 | * Pessimistic
 |
| * Hyperactivity
 | * Other:
 |

If you have been diagnosed with a psychological/ emotional problem, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other

|  |  |  |
| --- | --- | --- |
| * HIV/ AIDS
 | * Fibromyalgia
 | * Chronic Fatigue Syndrome
 |
| * Hepatitis
 | * Drug/ Alcohol Addiction
 | * Cancer:
 |
| * Strong Cravings
 | * Cold Back
 | * Strong Thirst
 |
| * Prefer Cold Drinks
 | * Prefer Hot Drinks
 | * Cold Abdomen
 |
| * Fevers
 | * Peculiar Tastes/ Smells
 | * Sweats Easily
 |
| * Excessive Sweating
 | * Sudden Drop in Energy
 | * Overall Poor Condition
 |
| * Lumps/ Bumps
 | * Chills
 | * Cold Hands
 |
| * Lack of Perspiration
 | * Bleed/ Bruise Easily
 | * Anemia
 |
| * Cold Feet
 | * Fatigue
 | * Bleed Excessively When Cut
 |
| * Heavy Appetite
 | * Poor Appetite
 | * Change in Appetite
 |

Describe your overall energy level:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Medical History

Has anyone in your family suffered from the following?

|  |  |  |
| --- | --- | --- |
| * Diabetes
 | * Asthma
 | * Cancer:
 |
| * Seizures
 | * High Blood Pressure
 | * Heart Disease
 |
| * Stroke
 | * Allergies
 | * Obesity
 |
| * Alcoholism
 | * Thyroid Problems
 | * Arthritis
 |
| * Psychological/ Emotional Problems
 | * High Cholesterol
 |  |

Lifestyle

Average Daily Diet

Breakfast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Habits/ Please Include Amount

|  |  |  |
| --- | --- | --- |
| * Cigarettes/ Per Day?
 | * Coffee/ Per Day?
 | * Tea/ Per Day?
 |
| * Alcohol/ Drinks Per Week?
 | * Sugar/ How Often?
 | * Table Salt/ How Often?
 |
| * Fatty Foods/ How Often?
 | * Soda/ How Often?
 | * Drugs/ How Often?
 |
| * Other/ Frequency?
 |

Do you exercise regularly? If so, what type and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much water do you drink daily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication List**

Please list all prescription and non-prescription medication, along with any vitamins, herbs, and supplements that you are currently taking.

|  |  |  |  |
| --- | --- | --- | --- |
| Medication/ Supplement | Dose | How Long? | How Often? |
|  |  |  |  |
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Please place an X on your problematic areas.

Notes:

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

**Informed Consent**

The above information is true to the best of my knowledge. I understand that I am financially responsible to Xu Wellness Center for payment at time service is rendered. I authorize Xu Wellness Center to contact me at the above contact information. I understand that I am responsible for all returned checks and must pay the price on the check plus a $30 bounced check fee. I understand that my personal information is private and will not be shared with anyone unless a written request is made to Xu Wellness Center written and signed by me.

It is my responsibility to inform Xu Wellness Center if any changes in my health occur. I am responsible for informing Xu Wellness Center of any and all health conditions, diseases or disorders from which I suffer. Serious health conditions or injuries will be referred to the appropriate physician, clinic, or hospital. I understand that I still need to continue any medical treatment that I am currently receiving.

I voluntarily consent to being treated by the medical staff at Xu Wellness Center in any of the following ways:

* Patient Health Evaluation/ General Medical Issues
* Bio Identical Hormone Replacement Therapy
* Lyme Disease
* Prolotherapy
* Allergy/ Sinus Issues
* IV Vitamin Therapy
* Injectable Vitamin Therapy
* Impulse Adjustment/ Chiropractic

I understand that I have the right to refuse treatment at any time, and I have the right to end my treatments at any time. I also understand that I have a right to ask whatever questions I have before, during, or after my treatments. I understand that Xu Wellness Center is not to be held responsible for any unexpected complications that may occur, and I understand that results are not guaranteed.

**I voluntarily consent to being treated by the medical staff of Xu Wellness Center, and I understand the treatment or treatments that I am about to receive. I have read this consent form, and I completely understand what I am signing. I consent to be treated at Xu Wellness Center, and I agree to abide by all terms and conditions before mentioned.**

**Patient Signature X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_

If under 18/ Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Doctor’s Use Only

Progress Notes

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