



ICBC and Motor Vehicle Accident Injury Form

Instructions: Please fill out as much information as possible. Answer each section; if you are unsure how to answer a question please bring it to the attention of the attending Doctor or front desk personnel.

1. Billing Information

Name: _____ Date of Birth: (M) ____/ (D) ____/ (Y) ____ Age: ____
Address: _____ Postal Code: _____
Phone# (H) _____ (B) _____ (C) _____
Email Address: _____
Occupation: _____ Number of Family Members in Accident: ____
B.C. Health Care Card #: _____ ICBC Claim #: _____
Family Physician Name and Office Location: _____
Claim Adjuster's Name and Phone #: _____

2. Auto Accident Description

Date of Car Accident: (M) ____/ (D) ____/ (Y) ____
Approximate Time of Car Accident: _____ AM PM
What was the estimate damage to your vehicle? \$ _____

- Yes No Have you reported this injury to ICBC (car insurance)?
 Yes No Did the police come to the accident scene and make a report?
 Yes No Is an attorney representing you? Name/Address/Phone: _____

Describe how the crash happened: _____

Collision Description

Check all that apply to you:

- Single-car crash 2-vehicle crash More than 3 vehicles
 Rear-end crash Side crash Rollover
 Head-on crash Hit guard-rail/object Ran off road

You were the

- Driver Front Passenger Rear Passenger

Describe the Vehicle you were in

Model year and make: _____

- Subcompact Compact Mid-sized car
 Full-sized car Pickup truck Larger than a 1 ton vehicle

2. Auto Accident Description Cont'd

Describe the other Vehicle(s)

- Subcompact Compact Mid-sized car
 Full-sized car Pickup truck Larger than a 1 ton vehicle

Estimate Crash Speeds

Estimate how fast your vehicle was moving at time of crash: _____ KM

Estimate how fast the other vehicle was moving at time of crash: _____ KM

At the time of impact your vehicle was

- Slowing down Stopped Gaining Speed Moving at a steady speed

At the time of impact the other vehicle was

- Slowing down Stopped Gaining Speed Moving at a steady speed

During and after the crash, your vehicle

- Kept going straight, not hitting anything Spun around, not hitting anything
 Kept going straight, hitting car in front Spun around, hitting another car
 Was hit by another vehicle Spun around, hitting object other than a Vehicle

Describe yourself during the crash

Check only the areas that apply to you:

- You were unaware of the impending crash
 You were aware of the impending crash and relaxed before the collision
 You were aware of the impending crash and braced yourself
 Your body, torso, and head were facing straight ahead
 You had your head and/or torso turned at the time of collision
 turned to the left turned to the right
 You were intoxicated (alcohol) at the time of crash
 You were wearing a seat belt
 If yes, does your seat belt have a shoulder harness? Yes No
 You were holding onto the steering wheel at the time of impact

Indicate if your body hit something or was hit by any of the following:

Please draw lines and match the left side to the right side

Head	Windshield
Face	Steering Wheel
Shoulder	Side Door
Neck	Dashboard
Chest	Car Frame
Hip	Another Occupant
Knee	Seat
Foot	Seatbelt

Check if any of the following vehicle parts broke, bent or were damaged in your car

- Windshield Seat Frame Knee Bolster Steering Wheel
 Side/Rear Window Dash Mirror Other: _____

2. Auto Accident Description Cont'd

Rear-end collision only

Answer this section only if you were hit from the rear

Does your vehicle have:

- Movable head restraints
- Fixed, non moveable head restraints
- No head restraints

Please indicate how your head restraint was positioned at the time of the crash

- At the top of the back of your head
- Midway height of the back of your head
- Lower height of the back of the head
- Located at the level of your neck
- Located at the level of your shoulder blades (upper back) below the neck

Estimate the distance the back of your head and the front of the head restraint _____ inches or cm

All types of collisions

Answer this section regardless of the type of crash, indicating those relevant to your case

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car, dent inward during the crash? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the side door touch your body during the crash? |
| <input type="checkbox"/> | <input type="checkbox"/> | Was your hand(s) on the steering wheel or dash during the crash? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did your body slide under the seat belt? |
| <input type="checkbox"/> | <input type="checkbox"/> | Was the door(s) of your vehicle damaged to the point where you could not open the door? |

3. Doctors, Therapists, Tests and Treatment since the Injury

Name of Hospital Emergency Department visited: _____

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Did you go to the emergency department after the accident?
Time visited: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you go to the emergency department in an ambulance? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you or another person drive you to the emergency department? |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you hospitalized overnight? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the emergency department doctor take X-rays? Check what was taken?
<input type="checkbox"/> Skull <input type="checkbox"/> Neck <input type="checkbox"/> Low back <input type="checkbox"/> Arm or Leg <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the emergency department doctor give you pain medications? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did the emergency department doctor give you muscle relaxants? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you have any cuts or lacerations? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you require any stitches for cuts? |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you given a neck or back brace to wear? |

If you did not see a doctor for the first time within the first week, indicate why

Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> No pain was noticed | <input type="checkbox"/> I thought the pain would go away |
| <input type="checkbox"/> No transportation | <input type="checkbox"/> No appointment available |
| <input type="checkbox"/> I had no insurance or money | <input type="checkbox"/> I took hot showers, used ice, heat |
| <input type="checkbox"/> Work/home schedule conflicts | <input type="checkbox"/> I self-treated with over-the-counter drugs |

3. Doctors, Therapists, Tests and Treatment since the Injury cont'd

Start with the first doctor/office/hospital you saw after your injury and check all that apply:

A. Name hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

- | | |
|--|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Medications prescribed |
| <input type="checkbox"/> X-ray of neck | <input type="checkbox"/> Neck collar |
| <input type="checkbox"/> X-ray of low back | <input type="checkbox"/> Spinal manipulation/adjustments |
| <input type="checkbox"/> Other X-rays | <input type="checkbox"/> Muscle massage and manual therapy |
| <input type="checkbox"/> MRI/ CT scan | <input type="checkbox"/> Low back brace |
| <input type="checkbox"/> Other diagnostics _____ | <input type="checkbox"/> Heat packs |
| <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Cold/ ice packs |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Exercise recommended | <input type="checkbox"/> Other _____ |

Indicate if treatment: made condition worse did not help helped

B. Name hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

- | | |
|--|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Medications prescribed |
| <input type="checkbox"/> X-ray of neck | <input type="checkbox"/> Neck collar |
| <input type="checkbox"/> X-ray of low back | <input type="checkbox"/> Spinal manipulation/adjustments |
| <input type="checkbox"/> Other X-rays | <input type="checkbox"/> Muscle massage and manual therapy |
| <input type="checkbox"/> MRI/ CT scan | <input type="checkbox"/> Low back brace |
| <input type="checkbox"/> Other diagnostics _____ | <input type="checkbox"/> Heat packs |
| <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Cold/ ice packs |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Exercise recommended | <input type="checkbox"/> Other _____ |

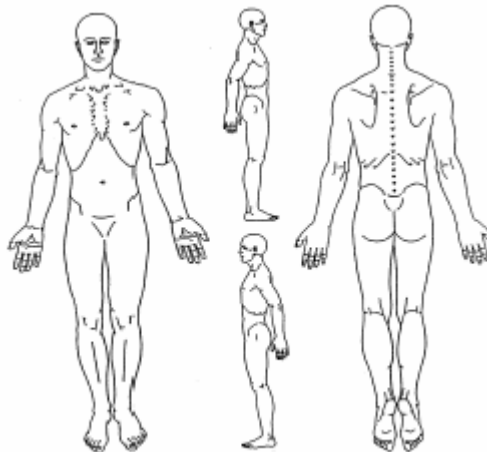
Indicate if treatment: made condition worse did not help helped

When did you first notice any pain after the injury?

Immediately _____ hours after the accident _____ Days after the accident

Use the following picture to show where your injury or pain is presently

KEY:
A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



4. Time Line for Current Injuries

It is important for this section to be filled out in detail. CHECK if you had any single or multiple symptom(s) listed below. Leave row blank if the symptom listed does not apply to you.

Symptom List (circle what applies)	Felt Right After Injury	Felt 24-48 Hours Later	Have Symptoms Now	Had Similar Symptoms 1-3 months before this injury
Headache				
Dizziness				
Ringing ear(s)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw pain				
Neck pain or soreness				
Neck stiffness				
Shoulder pain or stiffness				
Arm pain or tingling or numbness				
Wrist pain or numbness				
Hand pain or numbness				
Finger pain or numbness				
Weakness in arms				
Weakness in legs				
Upper-mid back pain				
Rib pain				
Lower back pain or soreness				
Hip pain				
Leg pain				
Leg numbness and tingling				
Pain shoots down legs				
Knee pain				
Ankle pain				
Foot pain				
Other				

Have you been able to work since the injury?

Yes
 No
 If No, you were off work:
 partially or
 completely
 Please list dates off work: _____ to _____

Signature: _____

Date _____

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and **mark in each section only the one box that applies to you**. We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

<p>Section 1: Pain Intensity</p> <p><input type="checkbox"/> I have no pain at the moment</p> <p><input type="checkbox"/> The pain is very mild at the moment</p> <p><input type="checkbox"/> The pain is moderate at the moment</p> <p><input type="checkbox"/> The pain is fairly severe at the moment</p> <p><input type="checkbox"/> The pain is very severe at the moment</p> <p><input type="checkbox"/> The pain is the worst imaginable at the moment</p>	<p>Section 2: Personal Care (Washing, Dressing, etc.)</p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain</p> <p><input type="checkbox"/> I can look after myself normally but it causes extra pain</p> <p><input type="checkbox"/> It is painful to look after myself and I am slow and careful</p> <p><input type="checkbox"/> I need some help but can manage most of my personal care</p> <p><input type="checkbox"/> I need help every day in most aspects of self care</p> <p><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed</p>
<p>Section 3: Lifting</p> <p><input type="checkbox"/> I can lift heavy weights without extra pain</p> <p><input type="checkbox"/> I can lift heavy weights but it gives extra pain</p> <p><input type="checkbox"/> Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned</p> <p><input type="checkbox"/> I can only lift very light weights</p> <p><input type="checkbox"/> I cannot lift or carry anything</p>	<p>Section 4: Reading</p> <p><input type="checkbox"/> I can read as much as I want to with no pain in my neck</p> <p><input type="checkbox"/> I can read as much as I want to with slight pain in my neck</p> <p><input type="checkbox"/> I can read as much as I want to with moderate pain in my neck</p> <p><input type="checkbox"/> I can't read as much as I want because of moderate pain in my neck</p> <p><input type="checkbox"/> I can hardly read at all because of severe pain in my neck</p> <p><input type="checkbox"/> I cannot read at all</p>
<p>Section 5: Headaches</p> <p><input type="checkbox"/> I have no headaches at all</p> <p><input type="checkbox"/> I have slight headaches, which come infrequently</p> <p><input type="checkbox"/> I have moderate headaches, which come infrequently</p> <p><input type="checkbox"/> I have moderate headaches, which come frequently</p> <p><input type="checkbox"/> I have severe headaches, which come frequently</p> <p><input type="checkbox"/> I have headaches almost all the time</p>	<p>Section 6: Concentration</p> <p><input type="checkbox"/> I can concentrate fully when I want to with no difficulty</p> <p><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty</p> <p><input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to</p> <p><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to</p> <p><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to</p> <p><input type="checkbox"/> I cannot concentrate at all</p>
<p>Section 7: Work</p> <p><input type="checkbox"/> I can do as much work as I want to</p> <p><input type="checkbox"/> I can only do my usual work, but no more</p> <p><input type="checkbox"/> I can do most of my usual work, but no more</p> <p><input type="checkbox"/> I cannot do my usual work</p> <p><input type="checkbox"/> I can hardly do any work at all</p> <p><input type="checkbox"/> I can't do any work at all</p>	<p>Section 8: Driving</p> <p><input type="checkbox"/> I can drive my car without any neck pain</p> <p><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck</p> <p><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck</p> <p><input type="checkbox"/> I can't drive my car as long as I want because of moderate pain in my neck</p> <p><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck</p> <p><input type="checkbox"/> I can't drive my car at all</p>
<p>Section 9: Sleeping</p> <p><input type="checkbox"/> I have no trouble sleeping</p> <p><input type="checkbox"/> My sleep is slightly disturbed (less than 1 hr sleepless)</p> <p><input type="checkbox"/> My sleep is mildly disturbed (1-2 hrs sleepless)</p> <p><input type="checkbox"/> My sleep is moderately disturbed (2-3 hrs sleepless)</p> <p><input type="checkbox"/> My sleep is greatly disturbed (3-5 hrs sleepless)</p> <p><input type="checkbox"/> My sleep is completely disturbed (5-7 hrs sleepless)</p>	<p>Section 10: Recreation</p> <p><input type="checkbox"/> I am able to engage in all my recreation activities with no neck pain at all</p> <p><input type="checkbox"/> I am able to engage in all my recreation activities, with some pain in my neck</p> <p><input type="checkbox"/> I am able to engage in most, but not all of my usual recreation activities because of pain in my neck</p> <p><input type="checkbox"/> I am able to engage in a few of my usual recreation activities because of pain in my neck</p> <p><input type="checkbox"/> I can hardly do any recreation activities because of pain in my neck</p> <p><input type="checkbox"/> I can't do any recreation activities at all</p>

Score: _____ (50)

Disability Index Score: _____ %

Signature: _____

Date _____

LOW BACK DISABILITY INDEX

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please just circle the one choice which closely describes your problem right now**

SECTION 1--Pain Intensity <input type="checkbox"/> The pain comes and goes and is very mild. <input type="checkbox"/> The pain is mild and does not vary much. <input type="checkbox"/> The pain comes and goes and is moderate. <input type="checkbox"/> The pain is moderate and does not vary much. <input type="checkbox"/> The pain is severe but comes and goes. <input type="checkbox"/> The pain is severe and does not vary much.	SECTION 6 -- Standing <input type="checkbox"/> I can stand as long as I want without pain <input type="checkbox"/> I have some pain while standing, but it does not increase with time. <input type="checkbox"/> I cannot stand for longer than one hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than 1/2 hour without increasing pain. <input type="checkbox"/> I can't stand for more than 10 minutes without increasing pain. <input type="checkbox"/> I avoid standing because it increases pain right away.
SECTION 2--Personal Care <input type="checkbox"/> I would not have to change my way of washing or dressing in order to avoid pain. <input type="checkbox"/> I do not normally change my way of washing or dressing even though it causes some pain. <input type="checkbox"/> Washing and dressing increase the pain, but I manage not to change my way of doing it. <input type="checkbox"/> Washing and dressing increase the pain and I it necessary to change my way of doing it. <input type="checkbox"/> Because of the pain, I am unable to do any washing and dressing without help. <input type="checkbox"/> Because of the pain, I am unable to do any washing or dressing without help.	SECTION 7--Sleeping <input type="checkbox"/> I get no pain in bed. <input type="checkbox"/> I get pain in bed, but it does not prevent me from sleeping. <input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than one-quarter. <input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than one half. <input type="checkbox"/> Because of pain, my normal night's sleep is reduced by less than three-quarters. <input type="checkbox"/> Pain prevents me from sleeping at all.
SECTION 3--Lifting <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights, but it causes extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can only lift very light weights, at the most.	SECTION 8--Social Life <input type="checkbox"/> My social life is normal and gives me no pain. <input type="checkbox"/> My social life is normal, but increases the degree of my pain. <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc. <input type="checkbox"/> Pain has restricted my social life and I do not go out very often. <input type="checkbox"/> Pain has restricted my social, life to my home. <input type="checkbox"/> Pain prevents me from social, life at all.
SECTION 4 --Walking <input type="checkbox"/> Pain does not prevent me from walking any distance. <input type="checkbox"/> I have some pain with walking but it does not increase with distance. <input type="checkbox"/> Pain prevents me from walking more than one mile. <input type="checkbox"/> Pain prevents me from walking more than 1/2 mile. <input type="checkbox"/> I can only walk while using a cane or on crutches. <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.	SECTION 9--Traveling <input type="checkbox"/> I get no pain while traveling. <input type="checkbox"/> I get some pain while traveling, but none of my usual forms of travel make it any worse. <input type="checkbox"/> I get extra pain while traveling, but it does not compel me to seek alternative forms of travel. <input type="checkbox"/> I get extra pain while traveling which compels me to seek alternative forms of travel. <input type="checkbox"/> Pain restricts all forms off travel. <input type="checkbox"/> Pain prevents all forms of travel except that done lying down.
SECTION 5—Sitting <input type="checkbox"/> I can sit in any chair as long as I like without pain. <input type="checkbox"/> I can only sit in my favorite chair as long as I like. <input type="checkbox"/> Pain prevents me from sitting more than one hour. <input type="checkbox"/> Pain prevents me from sitting more than 1/2 hour. <input type="checkbox"/> Pain prevents me from sitting more than ten minutes. <input type="checkbox"/> Pain prevents me from sitting at all.	SECTION 10--Changing Degree of Pain <input type="checkbox"/> My pain is rapidly getting better. <input type="checkbox"/> My pain fluctuates, but overall is definitely getting better. <input type="checkbox"/> My pain seems to be getting better, but improvement is slow at present. <input type="checkbox"/> My pain is neither getting better nor worse. <input type="checkbox"/> My pain is gradually worsening. <input type="checkbox"/> My pain is rapidly worsening.

Score: _____ (50)

Disability Index Score: _____ %

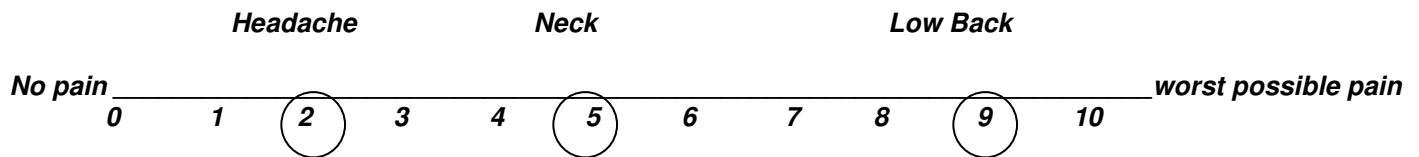
Signature : _____

Date _____

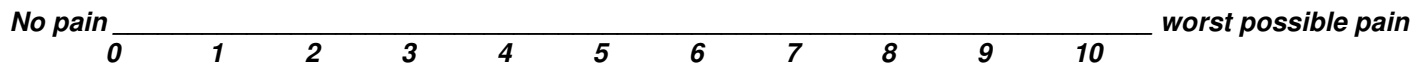
QUADRUPLE VISUAL ANALOGUE SCALE

Please read carefully: **Circle** the number that best describes the question being asked. **Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. **Please indicate your pain level right now, average pain, and pain at its best and worst.**

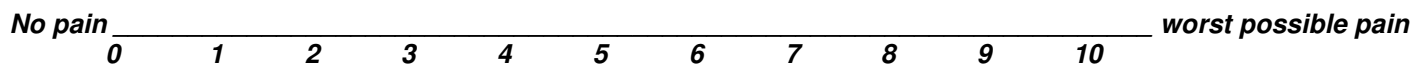
Example:



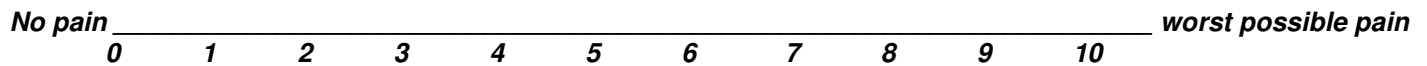
1 – What is your pain **RIGHT NOW**?



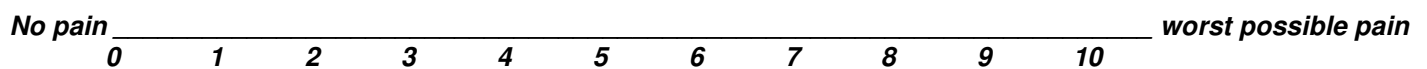
2 – What is your **TYPICAL** or **AVERAGE** pain?



3 – What is your pain level **AT ITS BEST** (How close to “0” does your pain get at its best)?



4 – What is your pain level **AT ITS WORST** (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Signature: _____ Date: _____

The Roland – Morris Low Back Pain and Disability Questionnaire

Please read instructions: when your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- I stay at home most of the time because of my back.
- I change position frequently to try to get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back, I am not doing any jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more often.
- Because of my back, I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly than usual because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel down.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back.
- I have trouble putting on my sock (or stockings) because of the pain in my back.
- I can only walk short distances because of my back pain.
- I sleep less well because of my back.
- Because of my back pain, I get dressed with the help of someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

Score: _____ (24)

Improvement: _____ %

INFORMED CONSENT TO CHIROPRACTIC EXAM &/OR CARE

In-Joy Life Wellness Group

There are risks and possible risks associated with the manual therapy techniques used by doctors of chiropractic. In particular you should note:

- A) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- B) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- C) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- D) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____

Patient signature (Legal Guardian)

Witness of Signature

Name: _____
(Please print)

Name: _____
(Please print)