

Confidential Patient Case History

Today's Date: _____

Please complete this questionnaire. This confidential patient case history will become part of your permanent records. Thank you.

Your Demographic Information

Last Name _____ First Name _____ M.I. _____
 Street _____
 City, State, Zip _____
 Email _____
 Home phone _____ Work Phone _____
 Cell Phone _____ Fax number _____
 Date of Birth _____ Sex: F M
 Social Security Number _____
 Emergency Contact Name _____ Phone Number _____
 Your Occupation _____ Employer _____

Your Pregnancy and Familial Status

Marital Status: M S D W Spouse's Name _____
 Children names and ages _____
 Are you pregnant: Y N If yes, How many weeks _____ Due Date: _____
 Ob/Gyn name and hospital you are using for this pregnancy: _____
 Was becoming pregnant stressful? Y N Did you conceive naturally? Y N
 How would you describe your pregnancy so far: Easy 1 2 3 4 5 6 7 8 9 10 Difficult
 Past Pregnancy/labor and delivery information: C-section. Induction. Complication. Episiotomy. Pre-eclampsia/Eclampsia
 Post Partum conditions from past pregnancies: Incontinence. Weight Gain. Hashimoto's Thyroidosis. Metabolic Change. Depression

Information about your journey to our office

Who referred you to us? _____
 How else did you hear about us? _____
 Were you given accurate directions to find UHI? Y N
 How did you travel here? Car. Bus. Train. Cab. Bicycle. Walk.
 Did you find parking? Y N Where? Flasher Zone. Meter. Parking Garage _____

Information about your experience with Natural Health Care

Have you seen a Chiropractic Doctor before? Y N If yes, who? _____
 Where is the doctor's office? _____
 If yes, what was your experience; if no, what have you heard about chiropractic? _____

 Have you used any other Natural Health Care before? Y N
 If yes, what kind of natural health care? Acupuncture. Massage Therapy. CranioSacral Therapy. Psychotherapy .
 Energy Medicine. Therapeutic Touch. Other _____

In this box, describe your main problem only.

If we could help you with **one** health **problem**, what would it be? Write your main problem/complaint here:

Answer the 10 most important questions about your problem here:

1. How long have you been suffering from this problem/complaint? When did it start? (month/year)

2. How many days out of the week or month do you find yourself suffering from this problem?
Be specific, please. Circle one: Every day Every other day Several (How many times per month _____)

3. How long will it last on a bad day? _____

4. Have you had this or a similar condition in the past? Y N

If yes, describe is here (and, was it related to or during previous pregnancies) _____

5. Has the problem been getting worse? Y N

6. When the problem is at its worst, exactly what does it feel like? _____

7. On a scale of 1-10, with 10 being the worst, how would you rate this problem right now? _____

8. On a scale of 1-10, with 10 being the worst, how would you rate this problem in the last week? _____

9. What do you do that makes this problem worse? _____

10. Many people tell us their condition makes them feel older than they are. Have you experienced this? Y N

How does it make you feel? _____

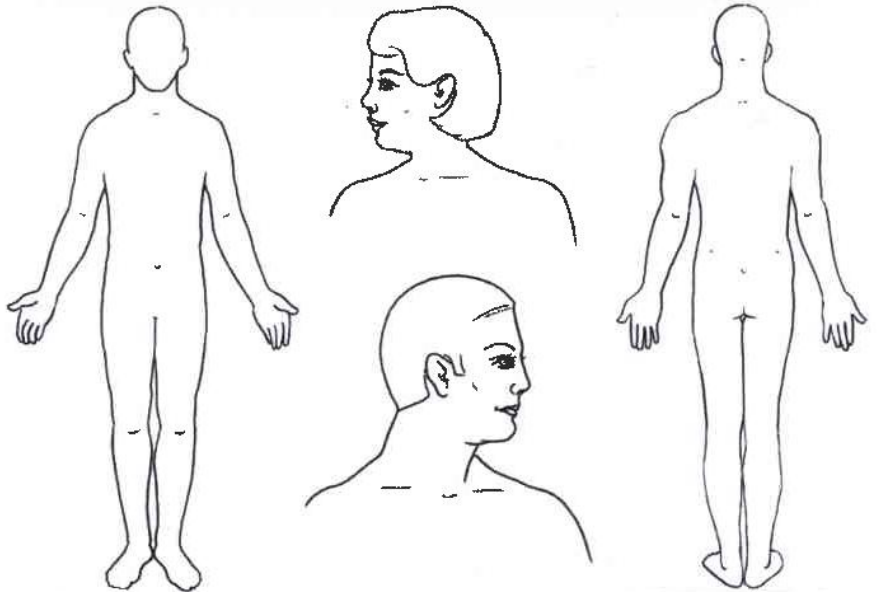
Mark the areas of your symptoms on the figures on the right. Use the following symbols to describe them:

Aches +++++

Numbness *****

Pins/Needles -----

Stabbing ///////



Describe what caused your problem.

Do you think that a specific accident/injury/trauma caused this problem? Y N

If yes, what was the event? _____

Do you think it is simply pregnancy related? Y N

Have you had any falls or accidents in the past that may have caused injury to your neck and spine, even as a child?

Y N. If yes, please describe _____

In this box, describe how you have tried to manage this problem:

Since the time you began suffering from this problem, what, if anything have you tried as a remedy or cure that did not work (please circle all that apply to the main problem): Ice. Heat. Rest. Over-the-counter drugs. Physical therapy. Exercise. Stretching. Massage. Prescription drugs. Doctor advice. Ignoring it. Waiting. Change in diet. Change in Habits. Staying away from activities. Prayer. Meditation. Wishing. Concentrating. Acupuncture. Changing activities. Limiting activities. Sleep. Nutrition counseling.

Anything else that you have tried to do to help this problem? _____

Has anything given you relief? Y N If yes, what was it that gave you the most relief? _____

Even if you experienced temporary relief, has anything you tried thus far fixed the problem? _____

In this box, describe how this problem is affecting you:

What activity does this prevent you from doing either partially or totally, that you would really like to be doing again if you didn't have this condition? _____

How does this problem prevent you from doing that? _____

What areas of your life is it most affecting (circle all that apply): My work. My social activities. My sports.

My ability to rest. My family life. My attitude. My financial plan. My personal life. My productivity.

My appetite. My interest in others. My personal hygiene. My mental state.

Other _____

Has this problem affected your sleep patterns?

Trouble falling asleep because you are uncomfortable? Y N

Not enough restful sleep? Y N

Awakening in the middle of the night? Y N

Waking you earlier than you would normally awake? Y N

Have you become discouraged about this? Y N

If you are not discouraged, does it concern you that your problem persists? Y N

If yes, why? _____

Are you concerned that it will not go away or get worse in the future? Y N

How often are you able to keep a positive attitude? Circle one:

Most of the time Some of the time Not very often Hardly at all

If you don't get this problem taken care of, where do you think you'll be in five years? _____

Are you ready to take care of this problem?

Taking into consideration what you have described so far, do you feel you need to change the way you have been dealing with this problem? Y N

On a scale of 1-10, 10 being the highest, how would you rate your commitment to getting rid of this problem? 1 2 3 4 5 6 7 8 9 10

Is there anything preventing you from getting this problem taken care of? Please specify your concerns: Money. Time. A Deadline. Fear of Care. Other: _____

Other health problems you have that bothered you in the last six months

If you have any other problems/complaints, please list them here:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

When was the last time you experienced the problems listed above?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Do you take any medications right now? Y N

Medication

How long have you taken this medication?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Did you have to get off or on any medications during pregnancy? Which ones? _____

General Information

My current weight _____ Height _____

Have you lost or gained weight so far during your pregnancy? Lost Gained How much? _____

How have your eating habits changed during pregnancy? _____

Are you working? Y N If yes, Full or Part Time (circle one)

Will you take a maternity leave? Y N N/A If yes, how long? _____

My work load is (circle):

Mental Work	Heavy	Moderate	Light	_____ hours/day
Physical Work	Heavy	Moderate	Light	_____ hours/day
Exercise	Heavy	Moderate	Light	_____ hours/day

My habits (circle):

Cigarette Smoking	Current	Yes	No	_____ packs/day, _____ years
	Past	Yes	No	_____ packs/day, _____ years
Alcohol use	Beer/week	_____	for	_____ years
	Wine/week	_____	for	_____ years
	Liquor/week	_____	for	_____ years
Caffeine use	Coffee/day	_____	for	_____ years
	Tea/day	_____	for	_____ years
Aspirin use	Aspirin/day	_____	for	_____ years

Doctor visits

Do you have a family physician? Y N What is the name of your doctor? _____

Address or hospital affiliation: _____

Do you see this doctor each year for a physical exam? Y N When was the last time you saw this doctor? _____

Are you satisfied with the care you received from this doctor? Y N

Do you see any specialists? Y N Names and specialties:

1. _____
2. _____
3. _____

Pregnancy/Post Partum Concerns

Does any part of pregnancy concern you? Y N If yes, what concerns you? _____

Have you chosen to deliver at a hospital? Y N

Do you know what hospital protocols are routine as far as treatment of you and your newborn child? Y N

UHI reminder: You are not beholden to many of the routine protocols enacted by the hospital, would you like more information on this matter? Y N

Does any part of labor and delivery concern you? Y N If yes, what concerns you? _____

Does any part of the post delivery period concern you? Y N If yes, what concerns you? _____

What books have you read, websites have you visited, or experts you have consulted to prepare for your pregnancy and post pregnancy journey? _____

Are you interested in learning more information about choosing vaccinations for your child? Y N

Family History

List anything that you know about the sickness, disease or death of the following relatives:

	Age if living	State of Health	Age at death	Cause of death
Father				
Mother				
Sister(s)				
Brother(s)				
Grandmothers				
Grandfathers				

Past Diagnoses

Have you ever been diagnosed as having a disease? Y N

If yes, what was it? _____

Have you ever been diagnosed with:

Cancer? Y N

High or low blood pressure? Y N

Stroke? Y N

Have you ever suffered from:

Alcoholism? Y N

Drug addiction? Y N

Trauma History

Any trauma your body has suffered in the past is important to helping us help you. A trauma may be *obvious or non-obvious*. A trauma to your body could have happened last week, ten years ago, when you were three years old or during the birth process. *Please note that body trauma is most often related to a physical event, but may also be related to a chemical or a mental event.* This list may help you remember (please check all that apply):

Obvious Body Trauma

Non Obvious Trauma

<input type="checkbox"/> Car accident	<input type="checkbox"/> Always sleeping in a strained position
<input type="checkbox"/> Bike accident	<input type="checkbox"/> Sitting at a bad work station
<input type="checkbox"/> Ski accident	<input type="checkbox"/> Repetitive movements related to work (mouse use, hanging head over a desk, shoulder held phone)
<input type="checkbox"/> A bad sprain	<input type="checkbox"/> Repetitive movements related to sports (tennis, golf, baseball)
<input type="checkbox"/> Sports injury or accident	<input type="checkbox"/> Movements related to playing an instrument
<input type="checkbox"/> Roller-blading accident	<input type="checkbox"/> Years of small falls related to youth sports
<input type="checkbox"/> A fall	<input type="checkbox"/> Repeated carrying of a heavy bag
<input type="checkbox"/> Being stuck with an object	<input type="checkbox"/> Pregnancies too close together
<input type="checkbox"/> Something that made you bleed	<input type="checkbox"/> Birth process with forceps or difficult birth process
<input type="checkbox"/> Recreational injury	<input type="checkbox"/> Use of a drug that caused a reaction
<input type="checkbox"/> A violent birth process	<input type="checkbox"/> Mental trauma due to the death of a loved one, divorce, money, drug addiction, bankruptcy
<input type="checkbox"/> A childhood injury or accident	<input type="checkbox"/> Miscarriage
<input type="checkbox"/> A time when someone thought you were "really hurt"	<input type="checkbox"/> Failed or challenging efforts to become pregnant
<input type="checkbox"/> Surgery, any type	
<input type="checkbox"/> Injury while moving (home/work)	

Please use this space to list dates (year will suffice) of trauma to your body and include a brief description of each event:

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

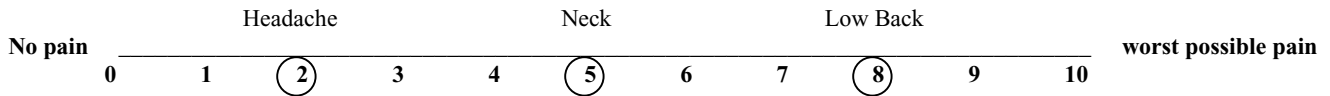
Date _____

Please read carefully:

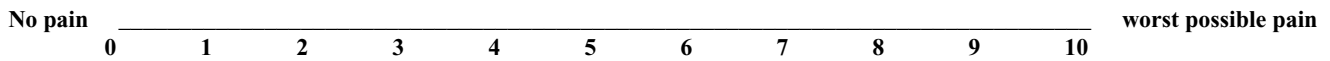
Instructions: Please circle the number that best describes the question being asked.

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.

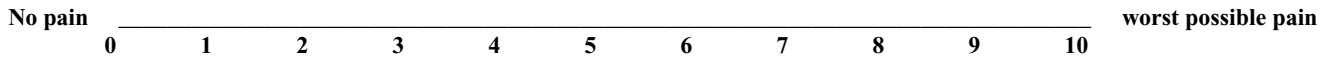
Example:



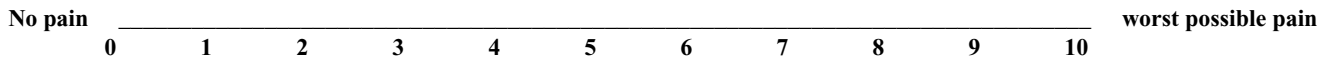
1 – What is your pain RIGHT NOW?



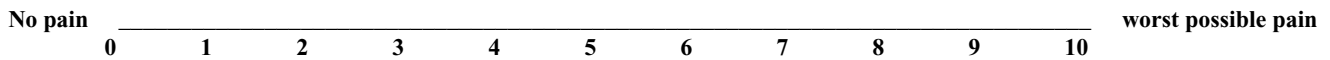
2 – What is your TYPICAL or AVERAGE pain?



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:

Examiner _____

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name _____

Date _____

Please read carefully:

This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ONE CHOICE which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box which most closely describes your problem right now.

SECTION 1 – Pain Intensity

- A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

- A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg, on a table
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 – Walking

- A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than 1/2 mile.
D. Pain prevents me from walking more than 1/4 mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

- A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me sitting more than 1 hour.
D. Pain prevents me sitting more than 1/2 hour.
E. Pain prevents me sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

OTHER COMMENTS:

SECTION 6 – Standing

- A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than 1/2 hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping

- A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 – Traveling

- A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

- A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

Examiner _____

With Permission from:Hudson-Cook N, Tomes-Nicholson K, Breen AC. A Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.

Universal Health Institute

Are you a doer, a hider? Are you beating yourself up? Are you a 'label'? Stress Strategies Screening Questionnaire

This questionnaire is used to identify the strategies you use to handle stressful challenges in your life. Why? If you are like most patients who come to UHI, you want to get better as quickly and as thoroughly as possible - and you are interested in doing it without a lot of drugs or surgery. Recognizing how you deal with stress is a fascinating process that helps you heal because once you know the strategies you use, you are in control of them, rather than vice versa. It's empowering.

Strategies for handling stress change over time, and though you use strategies habitually, you are probably blind to many of them. Once a strategy is put in front of you, you can choose whether it is really working for you, or whether it is working against you. If a strategy is working against you, it not only increases your stress, it complicates and interferes with the healing process.

Follow these instructions to complete the survey:

You might use the statements below to describe yourself or your situation. Read each one and determine if it describes you or fits your experience, and to what degree, during the past year. **Score the accuracy of the sentence is (using the Answers Table below)**. Score the sentence based on your emotional experience, *not using judgment*. Just refer to your emotional experience!

Some of the sentences refer to relationships. Relationships may include close friends, your parents or a romantic relationship. Look at each statement and score it based on the first person who comes to mind.

- If you are not currently in a romantic relationship, you can score the statement based on your most recent significant relationship.
- If your parent is no longer living, you can score the sentence based on your experience of the relationship when she or he was alive.
- If you are currently distant from your close friends, you may score the sentence based on your relationship with them, even though they are far away geographically.

Answers Table

1 = Completely untrue of me	4 = Moderately true of me
2 = Mostly untrue of me	5 = Mostly true of me
3 = Slightly more true than untrue	6 = Describes me perfectly

Using the Table, above, fill in the blank with the score that most properly reflects how accurately the statement describes you:

1. _____ I really missed having someone relate to me with warmth and affection, or who really understands me.

Answers Table

1 = Completely untrue of me	4 = Moderately true of me
2 = Mostly untrue of me	5 = Mostly true of me
3 = Slightly more true than untrue	6 = Describes me perfectly

2. _____ I feel like I really need people to be close to me, but I fear I will lose them, so I often cling to them.
3. _____ Its hard for me to feel like I can let my guard down with people. My sense is people often betray others.
4. _____ I often feel as though I'm really different from other people and don't really fit in.
5. _____ If someone really knew the inner me (or truth about me), they wouldn't like me .
6. _____ Other people are much better at handling most tasks in life than I am.
7. _____ I need help from others to manage most things in life.
8. _____ I am worried that some type of problem: financial, medical – even becoming a victim of crime - will happen to me.
9. _____ I often feel as though my life is so involved with others, I don't have a life of my own.
10. _____ If I don't do what others want of me, there will be negative results.
11. _____ Most of the time my life is focused on other people and their needs.
12. _____ I feel as though I must control my feelings; most people don't know how I feel about things.
13. _____ I really feel I have to be the best; its hard for me to make mistakes or just be "good enough"
14. _____ I feel that most rules are meant for others, I hate to be kept from doing what I want.
15. _____ If a goal isn't interesting or a task enjoyable, I lose interest easily or just don't do it.
16. _____ I feel most worthwhile when others notice my accomplishments.
17. _____ If something positive occurs, its only natural to think that something negative will happen soon.
18. _____ If something goes wrong and its my fault, I should suffer the consequences.

Name: _____

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Universal Health Institute to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 312-266-9090. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

X _____
Patient's Signature

X _____
Witness

Name _____

Date _____

INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION

THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:

1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager, if it is applicable.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The "team" approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program.

Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the *best* exercise for you, if performed too early in your condition, may be your *worst* enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

I HAVE READ THE ABOVE AND UNDERSTAND THE RISKS AND BENEFITS OF THE REHABILITATION PROGRAM. I AGREE TO PARTICIPATE AND HAVE MY REHABILITATION INFORMATION RELEASED TO MY DOCTOR, INSURANCE CARRIER, ATTORNEY, OR DVR PERSONNEL IF REQUESTED.

SIGNATURE OF PARTICIPANT

DATE _____

SIGNATURE OF WITNESS

DATE _____

Universal Health Institute Financial Policy

We will verify your insurance benefits as a courtesy to you. Your insurance will provide a quote of benefits, not a guarantee of payment. Your insurance company retains the right to deny service payments and/or pay at a different percentage than quoted. Your insurance contract is between you, your employer, and your insurance company. We are not a party to that contract. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.____(initial).

Please note that the out-of-network benefits may apply if we are not contracted with your insurance company____(initial).

We do not accept or bill secondary insurance carriers.If you have Medicare and you have supplemental insurance, Medicare will send the claim to your secondary insurance on your behalf. ____ (initial).

If referrals or prescriptions are required by your insurance company, you are solely responsible for obtaining and keeping track of them.____(initial).

If your insurance company has not paid a claim within ninety (90) days of submission, you accept full responsibility for payment in full of any outstanding balance ____ (initial).

Your copayment, coinsurance and deductible must be paid at the time of service.____ (initial).

All services must be paid in full if you are satisfying a deductible set by your insurance copay. Any credits to your account will be applied to future visits____(initial).

If you discontinue care for any reason other than discharge by the doctor, all patient balances become immediately due and payable in full by you and you authorize us to use your credit card to collect full payment.____(initial).

In the case that an account becomes delinquent (90 days past due) and we are unable to charge your credit card for the balance due, your account will be turned over to a third-party collection agency. If this occurs, our staff will no longer handle the account and all correspondence and phone calls will be directed to our agency Keynote Consulting.____(initial).

All patients are required to maintain a valid credit card number on file with us. If you choose not to provide this information, we will not bill your insurance and you must pay cash for all service provided to you____(initial).

Cancellations:

Scheduled visits are available for all services at UHI. If you are unable to make your appointment, 24 hour notice must be given. If you make an appointment on another patient's behalf, you assume all financial responsibility for that appointment in the event of a cancellation or missed appointment. Any missed appointment carry a charge of \$50.00 (except for chiropractic adjustments). This fee are not covered by insurance and must be paid before scheduling another appointment.

This financial policy supercedes any and all previous financial policies, contracts, and agreements issued by Universal Health Institute.____(initial).

Card # _____ Expiration Date _____

CVV Code (3 digit number on the back of your card) _____

Printed Name as Appears on Card: _____

Signature: _____ Date: _____

Witness: _____ Date: _____