

Tom Etges, MD, LLC  
Family Medicine, Medical Acupuncture

**Please check all that apply:**    Primary Care    Medical Acupuncture    Both

Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  M  F/SSN# (For billing): \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Best daytime phone for us to call?    Cell    Home    Work   May we leave a message?    Yes    No

How did you hear about us? \_\_\_\_\_

Spouse/Partner Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Marital Status:  M  S  D  P  W/ # of children \_\_\_\_\_ Email: \_\_\_\_\_

Employment:  Full  Part  None  Student   Employer & Occupation: \_\_\_\_\_

Name of an Emergency Contact not living with you: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Phone: \_\_\_\_\_

Is this treatment work related? \_\_\_\_\_ If yes, what was the date of injury? \_\_\_\_\_

**If we are billing one of the insurances below, please allow us to copy your card and check which insurance.**  
If it is **NOT** one of the insurances listed, then please leave this blank as we are unable to bill any other carriers.

Lifewise    MODA Health    PacificSource    Regence BC/BS    Providence    Auto Accident    Worker's Comp

Insurance: \_\_\_\_\_ Primary Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Member ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**For all other insurance carriers, we are considered out-of-network. Please pay in full for your visit today.**

**Privacy policy:** I have received a copy of Tom Etges MD, LLC's "Notice of Privacy Practices," (hard copy upon request).

**Consent to treat:**

\_\_\_\_\_  
Legal signature / Relationship to patient Date

**Consent to treat a minor:**

As the legal guardian of the patient named above, I \_\_\_\_\_ (Print Name)  
hereby authorize Dr. Tom Etges or his assistant(s) to provide treatment to the minor.

\_\_\_\_\_  
Legal signature / Relationship to patient Date

**Tom Etges, MD, LLC  
Office Billing Policy**

I understand that it is my responsibility to provide the office with current, accurate billing information at the time of check in and to promptly notify the office of any changes to the information I provide.

We bill Lifewise of Oregon, MODA Health, PacificSource, and BC/BS insurance companies, as well as auto accident and worker's compensation insurance with an **open** claim and claim number. For other commercial insurance carriers, payment is expected on the date of service. We will provide you with documentation of your visit for you to submit to your insurance carrier for possible reimbursement. Because this office is not a participating provider for Medicare, Medicaid, or OHP plans, I am unable to bill for services for patients covered by these programs.

**Assignment of Insurance Benefits:** By my signature below, I authorize Tom Etges, MD and his agents to submit claims to my insurance carrier on my behalf and I authorize direct payment to him for all services rendered. I also authorize my personal health information to be released to my insurance carrier for billing purposes.

**Payment Policy:** If you have insurance that we are billing, your copayment or coinsurance, or any outstanding deductible portion is due at the time of service. It is a contractual agreement between your insurance carrier, you (the enrollee), and Tom Etges, MD to collect these fees on the day of service.

I understand that Tom Etges, MD, or his staff will obtain any necessary prior authorizations prior to my treatment. I also understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier. If we are unsuccessful at collecting payment from your insurance carrier for any reason, you are ultimately responsible for any balance due.

If time permits, and as a courtesy, we will verify your insurance eligibility, benefits, and patient financial responsibility amounts prior to your visit. We request you confirm your benefits with your insurance carrier since insurance benefits are a contract between you and your insurance carrier and you are ultimately financially responsible for payment of all services rendered to you.

I understand that I will be billed for any outstanding amounts due by me, and that I have a financial responsibility to pay these amounts within 30 days. Two (2) statements will be provided for any balance due and if payment is not received prior to the second mailing, then the second statement will be marked "Final Notice" and may be sent to an outside collection service if payment is not received within 10 days of the final notice. I also agree that I will be responsible for any collection, interest, or legal expenses associated with the collection of my debt.

**Cancellation Policy/ Fees:** If you are unable to keep a scheduled appointment, please contact us with a minimum 24 hours notice. If calling after hours, please leave a message in our secure voicemail system. If you miss your appointment, or do not give 24 hours notice of cancellation, you will be charged a fee of \$85, which is not billable to insurance and must be paid by you.

I understand and agree that if I present an NSF check for payment, I will be charged an NSF fee of \$35 and it is not billable to insurance. The \$35 fee, plus the outstanding balance, must be paid in full immediately by cash, money order, or valid credit card. I further understand that my account will be converted to a cash account and no more personal checks will be accepted by the office of Tom Etges, MD, LLC.

I understand that any request for Tom Etges, MD, to complete disability or medical program participation paperwork associated with my care will have a \$20 fee to complete the paperwork and is not billable to insurance and is due before the paperwork will be completed.

My signature below confirms that I have read and understand these billing policies and my financial obligation as they pertain to Tom Etges, MD, LLC.

Legal signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Main Complaint? \_\_\_\_\_

Did your main complaint come on: Gradually Suddenly Is it getting: better worse staying the same

When did symptoms begin? \_\_\_\_\_ What was the cause? \_\_\_\_\_

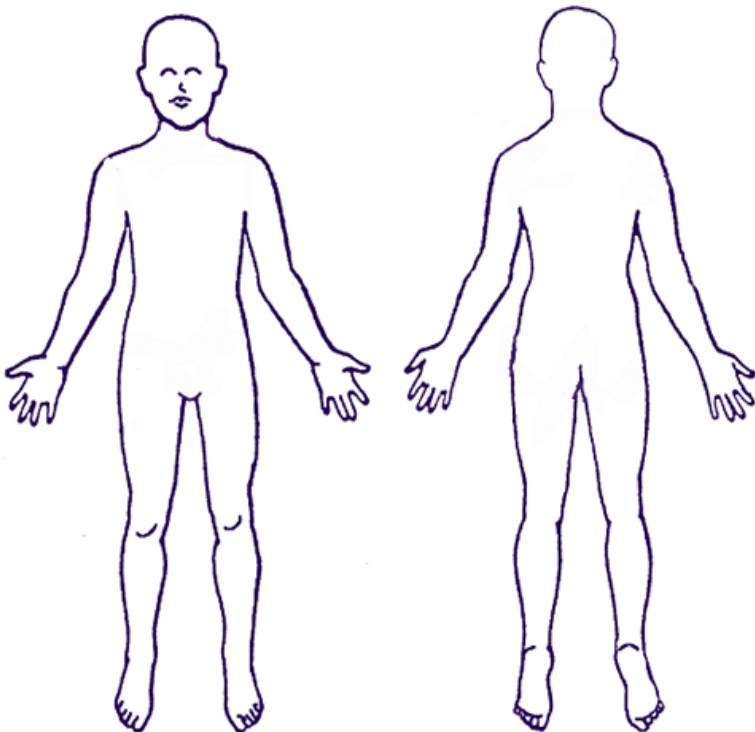
What makes it better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Have you had this problem in the past? Yes No If Yes, when? \_\_\_\_\_

Have you had acupuncture in the past? Yes No For what reason? \_\_\_\_\_

Have you had X-Rays, MRI, or CT Scan? Yes No If yes, on which body part? \_\_\_\_\_

Does this problem interfere with sleep? Yes No Please Circle below: C= currently, P= in the past, N= never



BODY DIAGRAM

Rate each pain on diagram on a scale of 1 (slight) to 10 (extreme)

- Headache C P N
- Migraine C P N
- Neck Pain C P N
- Mid-Back Pain C P N
- Lower-Back Pain C P N
- Shoulder Pain C P N
- Hip Pain C P N
- Knee Problems C P N
- Ankle Problems C P N
- Feet Problems C P N
- Fatigue C P N
- Gout C P N
- Constipation C P N
- Diarrhea C P N
- Urinary Problems C P N
- High Blood Pressure C P N
- Depression C P N
- Seizures C P N
- Paralysis C P N
- Muscle Weakness C P N
- Numbness or Tingling C P N
- Vertigo or Dizziness C P N
- Loss of Balance C P N
- Stroke C P N
- Loss of Smell C P N
- Fainting C P N
- Cancer C P N
- Varicose Veins C P N
- Osteoporosis C P N
- HIV C P N
- Hypoglycemia C P N
- Arthritis C P N
- Diabetes C P N
- Pregnant C P N

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Please list major and minor surgeries (with year or age)

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

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

When did you last go to a doctor's office, medical clinic, or hospital? What was the reason? \_\_\_\_\_

Please list significant traumas/accidents: \_\_\_\_\_

Please list all medications you take and their dosage: \_\_\_\_\_

Please list all Vitamin/Mineral/Herbs/Nutritional supplements you take and their dosage: \_\_\_\_\_

Please list any drug, food, or environmental allergies you have: \_\_\_\_\_

What are your health concerns in order of importance?

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

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

How do your health concerns affect your everyday living? \_\_\_\_\_

What do you feel needs to happen for you to get better? \_\_\_\_\_

When was the last time you felt well? \_\_\_\_\_

How much change are you willing to make (at this time) for improving your health?

- Minimal
- Some
- Complete

Place a mark on the line that best describes you currently. (Use the last 3 months for reference)

**Mood-** Extremely Depressed|-----|-----|-----|-----|-----|-----| Very Happy

**Overall Health** -Near Death|-----|-----|-----|-----|-----|-----| Extremely Healthy

Name: \_\_\_\_\_ Date: \_\_\_\_\_

For the following, please indicate your average (A) and worst (W) levels. (Use either the last 3 months or since there has been a problem, whichever is shorter).

**Energy Level-** None|-----|-----|-----|-----|-----|-----| Extremely Energetic  
**Pain Level-** None|-----|-----|-----|-----|-----|-----| Worst Pain Imaginable  
**Stress Level-** None|-----|-----|-----|-----|-----|-----| Extreme Stress

### Review of Systems

C= Currently P= In the Past N = Never

GENERAL

Weight \_\_\_\_\_  
 Maximum weight \_\_\_\_\_  
 When? \_\_\_\_\_  
 Height \_\_\_\_\_  
  
 Rate your energy on a scale  
 Of 1 to 10 \_\_\_\_\_  
 Time of day most  
 Energized? \_\_\_\_\_

MENTAL

Depression C P N  
 Mood Swings C P N  
 Anxiety/Nervousness C P N  
 Considered Suicide C P N  
 Tension C P N  
 Poor Concentration C P N  
 Easily Stressed C P N  
 Memory problems C P N

ENDOCRINE

Hypo/hyperthyroid C P N  
 Heat/cold intolerance C P N  
 Hypoglycemia C P N  
 Diabetes C P N  
 Excessive thirst C P N  
 Excessive hunger C P N  
 Fatigue C P N  
 Seasonal Depression C P N

IMMUNE

Vaccination reactions C P N  
 Recurrent infection C P N  
 Swollen glands C P N

HEAD

Headaches C P N  
 Head Injury C P N  
 Jaw Pain/ TMJ C P N

NECK

Lumps C P N  
 Swollen Gland C P N  
 Goiter C P N  
 Pain C P N

EYES

Spots in Vision C P N  
 Cataracts C P N  
 Impaired Vision C P N  
 Glasses or Contacts C P N  
 Blurriness C P N  
 Eye pain/strain C P N  
 Color blindness C P N  
 Tearing or dryness C P N  
 Double Vision C P N  
 Glaucoma C P N

EARS

Impaired hearing C P N  
 Ringing C P N  
 Earaches C P N  
 Dizziness C P N

NOSE/SINUSES

Frequent colds C P N  
 Nosebleeds C P N  
 Stuffiness C P N  
 Hay fever C P N  
 Sinusitis C P N

CARDIOVASCULAR

Heart Disease C P N  
 High/Low Blood Pressure C P N  
 Blood Clots C P N  
 Phlebitis C P N  
 Rheumatic Fever C P N  
 Swelling in Ankles C P N  
 Angina C P N  
 Murmurs C P N  
 Fainting C P N  
 Palpitations/Fluttering C P N  
 Chest Pain C P N

GASTROINTESTINAL

Heartburn C P N  
 Trouble Swallowing C P N  
 Change in thirst/appetite C P N  
 Nausea C P N  
 Vomiting C P N  
 Blood in Stool C P N  
 Pain or cramps C P N  
 Belching or passing gas C P N  
 Black stools C P N  
 Jaundice (yellow skin) C P N  
 Liver Disease C P N  
 Bowel Movements:  
   how often \_\_\_\_\_  
   is this a change? \_\_\_\_\_  
 Constipation C P N  
 Diarrhea C P N  
 Gallbladder disease C P N  
 Ulcer C P N  
 Hemorrhoids C P N  
  
URINARY  
 Pain on Urination C P N  
 Increased Frequency C P N

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**NEUROLOGIC**

Seizures C P N  
 Paralysis C P N  
 Muscle weakness C P N  
 Numbness or tingling C P N  
 Vertigo or dizziness C P N  
 Loss of balance C P N  
 Fainting C P N

**SKIN**

Rashes C P N  
 Eczema Hives C P N  
 Acne Boils C P N  
 Itching C P N  
 Color Changes C P N  
 Perpetual Hair Loss C P N  
 Lumps C P N  
 Night Sweats C P N

**MOUTH/THROAT**

Frequent Sore Throat C P N  
 Sore tongue C P N  
 Gum problems C P N  
 Hoarseness C P N  
 Dental cavities C P N

**RESPIRATORY**

Cough C P N  
 Coughing blood C P N  
 Asthma C P N  
 Pneumonia C P N  
 Emphysema C P N  
 Pain on Breathing C P N  
 Tuberculosis C P N  
 Sputum C P N  
 Wheezing C P N  
 Bronchitis C P N  
 Pleurisy C P N  
 Difficulty Breathing C P N  
 Shortness of Breath C P N

**URINARY Cont'd**

Frequency at night C P N  
 Inability to hold urine C P N  
 Frequent infections C P N  
 Kidney stones C P N

**MUSCULOSKELETAL**

Joint pain or stiffness C P N  
 Broken bones C P N  
 Muscle spasms or cramps C P N  
 Arthritis C P N  
 Weakness C P N  
 Sciatica C P N

**BLOOD**

Easy bleeding or bruising C P N  
 Deep leg pain C P N  
 Varicose Veins C P N  
 Anemia C P N  
 Cold Hands or Feet C P N  
 Thrombophlebitis C P N

**Review of Systems**

C= Currently P= In the Past N = Never

**FEMALE REPRODUCTIVE**

Age of first menses \_\_\_\_\_  
 Are cycles regular C P N  
 Date of last menstrual period \_\_\_\_\_  
 Number of Days Bleeding \_\_\_\_\_  
 Length of Cycle \_\_\_\_\_  
 Bleeding btwn cycles C P N  
 Painful menses C P N  
 Clotting C P N  
 Heavy/Excessive Flow C P N  
 Discharge C P N  
 PMS C P N  
 Pain during intercourse C P N  
 Birth Control Used C P N  
 Method: \_\_\_\_\_  
 Number of Pregnancies \_\_\_\_\_  
 Number of Live Births \_\_\_\_\_  
 Number of Miscarriage \_\_\_\_\_  
 Number of Abortions \_\_\_\_\_

Difficulty Conceiving C P N |  
 Endometriosis C P N |  
 Ovarian Cysts C P N |  
 Cervical Dysplasia C P N |  
 Abnormal PAP C P N |  
 Sexual difficulties C P N |  
 Venereal Disease C P N |  
 Are you sexually Active C P N |  
 Sexual Orientation: |  
 Heterosexual |  
 Bisexual |  
 Homosexual |  
 Do you do breast self exams: |  
 Y N Last one: \_\_\_\_\_ |  
 Breast Lumps C P N |  
 Breast Pain/Tenderness C P N |  
 Nipple Discharge C P N |  
 Menopausal Symptoms C P N |

**MALE REPRODUCTIVE**

Hernias C P N  
 Testicular pain C P N  
 Venereal Disease C P N  
 Are you sexually active C P N  
 Sexual Orientation:  
 Heterosexual  
 Bisexual  
 Homosexual  
 Impotence C P N  
 Premature ejaculation C P N  
 Birth Control Used C P N  
 Method: \_\_\_\_\_  
 Testicular Masses C P N  
 Prostate Disease C P N  
 Discharge or sores C P N

Is there any information you would like to add? \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### FAMILY HISTORY

#### Father

Health:  Good  Poor

Age (at death): \_\_\_\_\_

Cause of Death : \_\_\_\_\_

\_\_\_\_\_

#### Mother

Health:  Good  Poor

Age (at death): \_\_\_\_\_

Cause of Death: \_\_\_\_\_

\_\_\_\_\_

**Check the box for any of the following conditions that you or your family members have experienced:**

Cancer	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Diabetes	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Heart Disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
High Blood Press	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Stroke	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Epilepsy	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Mental Illness	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Asthma	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Hay Fever/Hives	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Anemia	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Kidney Disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Liver Disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Gallbladder Disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Ulcer	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Tuberculosis	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Goiter	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Arthritis	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Heart Murmur	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Cataracts	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____
Glaucoma	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sibling	<input type="checkbox"/> child	<input type="checkbox"/> other	_____

Is there any other information that you would like to add? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Medical Acupuncture Patient Information and Consent Form**

\*Please read this information carefully. Ask your practitioner if there is anything you do not understand.

### **What Is Acupuncture?**

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

### **Is Acupuncture Safe?**

Acupuncture is generally very safe. Serious side effects are very rare, less than one per 10,000 treatments.

### **Does Acupuncture Have Side Effects?**

You need to be aware that:

- Drowsiness occurs after treatment in a small number of patients. If affected, you are advised not to drive.
- Minor bleeding or bruising occurs after acupuncture in about 3% of patients.
- Pain during treatments occurs in about 1% of patients.
- Symptoms can get worse after treatment. Usually less than 3% of patients.
- You should tell your practitioner about any symptoms that worsen, but it is usually a good sign.
- Fainting can occur in certain patients, particularly with the first treatment.

In addition, if there are particular risks that apply to your treatment, Dr. Etges will discuss these with you.

### **Is there anything your practitioner needs to know?**

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have experienced a fit, faint, or funny turn
- If you have a pacemaker or any other electrical implants
- If you have a bleeding disorder
- If you are taking anti-coagulants or any other medication
- If you have damaged heart valves or have any other particular risk of infection
- If you are pregnant or might possibly be pregnant

**\*Note: ONLY single-use, sterile, disposable needles are used in this clinic for acupuncture treatments.**

### **Statement of Consent:**

I confirm that I have read and understand the above information, and I consent to having acupuncture treatment. I understand I can refuse treatment at any time. I understand Tom Etges is a medical doctor with training in acupuncture. He is not a licensed acupuncturist.

Full Printed Name: \_\_\_\_\_

Legal Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Medical Acupuncture**  
**Patient Information**  
**From Tom Etges, MD**

1. No form of therapy “cures” every ailment and acupuncture is no different. The number of treatments required before one experiences lasting results is usually related to the length of time the problem has existed. For longstanding conditions, 6-12 weekly sessions are usually recommended. For acute injuries or illness, treating within the first 24-48 hours is optimal and may initially be treated 1-2 times per week.
2. Initial acupuncture sessions can cause fatigue. Please avoid scheduling major activities the evening following your first few acupuncture appointments.
3. Initial response to your acupuncture treatments can include: no perceptible change, an improvement, or sometimes a temporary (usually less than 24 hours) worsening of symptoms. Please do not be discouraged if this transient worsening occurs. It may indicate that Qi, the body’s vital energy, has been affected, which often results in subsequent improvement in symptoms.
4. During a treatment, you will be provided with a button that activates a wireless chime. Please press the button if discomfort from electrical stimulation occurs, positional fatigue develops, or if a needle becomes uncomfortable, preventing you from relaxing.
5. Traditionally, it is recommended the following be avoided for 12 hours following an acupuncture treatment: alcohol, concentrated sweets, intense exercise, heavy or very rich foods, and sexual activity. The reasoning behind this is to encourage the free flowing of Qi generated during the acupuncture session to continue.
6. It is not unusual for an acupuncture point to remain sensitive for a few days. Local swelling and/or sometimes bruising can occur but is usually quite mild. Should symptoms become more severe or persist, please don’t hesitate to call the office. If you have any questions, please ask.
7. For additional information, I highly recommend the American Academy of Medical Acupuncture website: [www.medicalacupuncture.org](http://www.medicalacupuncture.org). At the bottom of the home page, listed under the Medical Acupuncture Learning Center, is a link entitled, “Doctor, what’s this acupuncture all about?” This information goes into even more detail about the style of acupuncture I practice.

**Primary Care Provider Information**

In an effort to provide your primary care physician (PCP) with updates about your progress with acupuncture, please provide us with the following information:

Name of current PCP: \_\_\_\_\_

Phone number of PCP: \_\_\_\_\_

Address (or street): \_\_\_\_\_

Name of other specialists and/or clinics where you have been or are currently receiving medical care:

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

If there is any other information about previous care you have received that you would like us to know about, please elaborate here:

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