30. Indicate the date of your last:

Physical examination _____

Laboratory tests _____

31. Is there any additional information that you would consider pertinent? ☐ **Yes** ☐ **No**

If yes, please specify _____

32. Do you wish to be included in our periodic follow-up assessment recall list? ☐ **Yes** ☐ **No**

I certify that the information I have given above is accurate and certify I will notify the office of any changes in my medical history immediately:

Client Signature _____ **Date** _____

(Please do not write below this line for Practitioner use only)

Temperature_____**Pulse**_____**Respirations**_____**Blood Pressure**_____**Skin Color**_____

Assessment and Evaluation for Treatment_____

_____

_____

_____

Selected Treatment Protocol_____

_____

_____

_____

_____ _____

Physician/Practitioner Signature **Date**