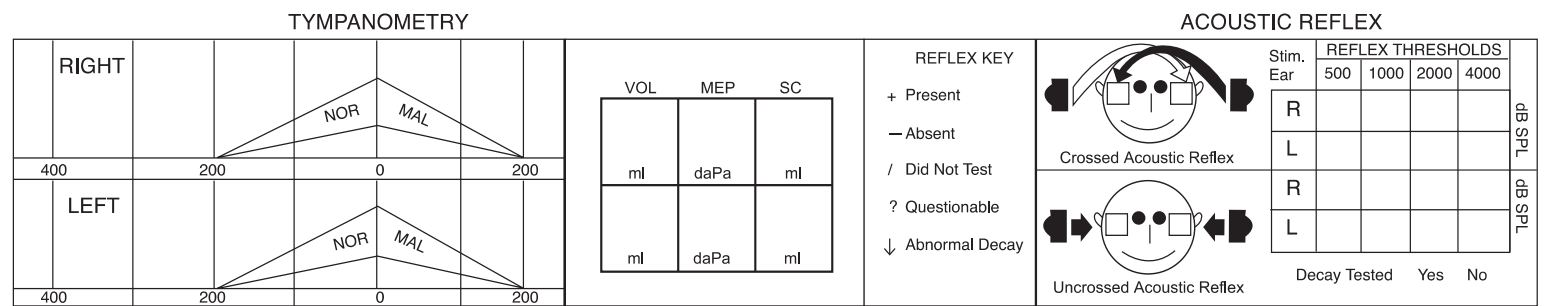
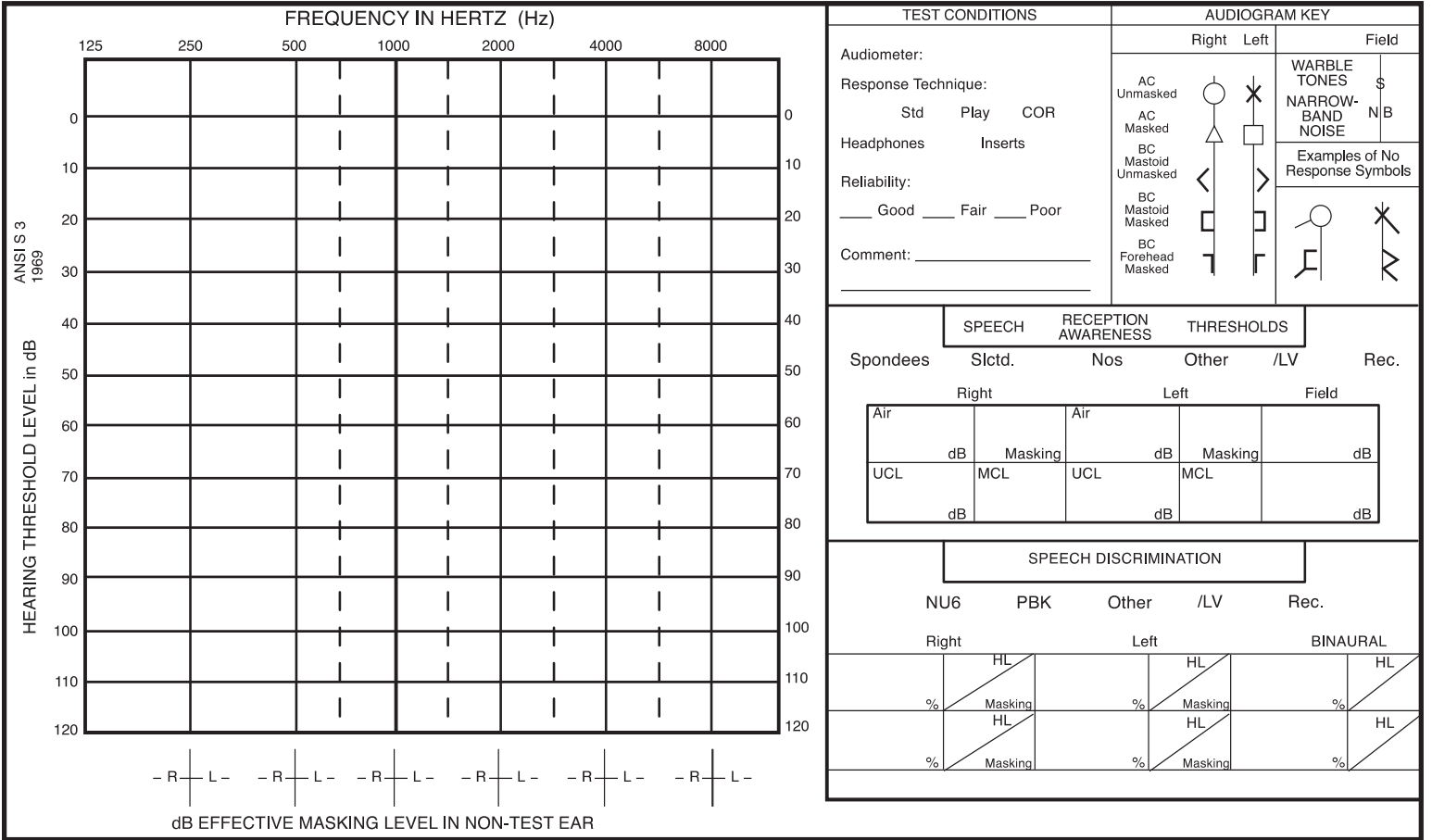


Healthcare Center Address:

NAME: _____ SEX: _____ AGE/DOB: _____

REFERRAL: _____ DATE OF EVALUATION: _____



Remarks:

Examiner