**Participant Health Profile**

*Welcome to Hands On Wellness! Please fill out everything on this form, even if you feel it does not apply to the reason you are coming in for care. Thank you for choosing us as part of your healthcare team.*

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**Please check the type of care desired:**

\_\_\_ Temporary Relief \_\_\_ Stabilization \_\_\_ Family Health/ Prevention \_\_\_Doctor’s Advice

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

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**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex**: Male / Female

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_/\_\_\_/\_\_\_ **Age**: \_\_\_\_ **Weight**: \_\_\_\_\_ **Height**: \_\_\_\_\_

**Married/Life Partner?** Yes\_\_\_ No\_\_\_ **Significant Other’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Children(’s) Name(s) and Age(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact**: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_

**Current Health Concerns**

What is the **primary reason** for your appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**When/how** did this concern first begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What activities **aggravate** your concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What activities **alleviate** your concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is the condition worse during certain times of the day? Y N If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it affectyour \_\_\_work / \_\_\_relationships or intimacy / \_\_\_decision making / \_\_\_exercise or play

\_\_\_attitude, mood, patience / \_\_\_ability to relax or sleep / \_\_\_ day-to-day activities

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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On a scale of 1-10 (1 least, 10 most), please circle the severity of your symptoms: 1 2 3 4 5 6 7 8 9 10

Do you have \_\_\_pain \_\_\_numbness \_\_\_tingling \_\_\_aches Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your pain \_\_\_sharp \_\_\_dull \_\_\_throbbing \_\_\_constant \_\_\_intermittent Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel \_\_\_swelling \_\_\_cramping \_\_\_stiffness \_\_\_burning Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other health concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mark all that apply with (N) for Now, (P) for Past**

\_\_\_Tobacco \_\_\_Alcohol \_\_\_Medications \_\_\_Recreational drugs \_\_\_Vaccinations \_\_\_Falls/injuries \_\_\_Accidents \_\_\_Surgeries/organs removed \_\_\_Dislocations/fractures \_\_\_Sports injuries \_\_\_Abuse (Physical, sexual, emotional?)

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Adult History** (Age 18 to present)

**Mark all that apply with (N) for Now, (P) for Past**

\_\_\_ Weight changes \_\_\_ Frequent Colds/Flu \_\_\_ Asthma/Respiratory disease \_\_\_ Sinus problems/Allergies

\_\_\_ Anemia \_\_\_ Skin Conditions \_\_\_ Neck/Back pain \_\_\_ High cholesterol

\_\_\_ Stroke \_\_\_ High blood pressure \_\_\_ Depression \_\_\_ Bipolar disorder

\_\_\_ OCD \_\_\_ AD/HD \_\_\_ SAD \_\_\_ Concussion/Head injury

\_\_\_ Digestive problems \_\_\_ Cancer \_\_\_ Menstrual problems/ pain \_\_\_ Numbness/Tingling

\_\_\_ Dental/Jaw issues \_\_\_ Headaches \_\_\_ Diabetes (Type:\_\_\_\_\_\_) \_\_\_ Urinary Tract Infections

\_\_\_ Arthritis (Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_ Bowel/bladder changes \_\_\_ Dizziness/Vertigo

\_\_\_ Ear/Hearing Issues \_\_\_ Eye/Vision Issues \_\_\_ Reproductive Organ Disorders \_\_\_ Thyroid Disorder

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Mark all that apply with (N) for Now, (P) for Past**

\_\_\_Particular diet (type:\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_ Vitamins or supplements (details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_Regular exercise (frequency?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_Occupational stress \_\_\_Mental/emotional stress \_\_\_Physical stress \_\_\_Chemical stress

**Sleep habits**: \_\_\_\_ Hours per night / \_\_\_\_Sound or \_\_\_\_Disrupted? / \_\_\_\_ Nightmares / \_\_\_\_ Sleep apnea / \_\_\_\_ Snoring Age of mattress \_\_\_\_ yrs / Type of mattress \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age of pillows \_\_\_\_\_ yrs / Type of pillows \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / Locations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diet**

Daily/High Weekly/Moderate Monthly or less/Low None/Never

Dairy (milk, yogurt, cheese) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Meat \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Vegetables \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Fruit \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Gluten (flour, wheat, pasta) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Soy \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Sugar \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Soda/Energy Drinks \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Fast food \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Caffeine \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Circle all that apply if mom is breastfeeding: caffeine, coffee, tea, alcohol, tobacco, medications of any type

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Environmental Habits

Do you filter your drinking/cooking/shower water? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What types of cleaning/ home/ yard products do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use organic health products (soaps, shampoos, detergents)? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you filter your air at home? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you notice any mold or environmental toxins in/around your home or work place Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other Environmental concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel **impair** your opportunity for full, unimpeded health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any particular factors or elements about your life, experiences, family, work, recreation, genetics, dietary programs, exercises, outlook, etc. that you feel give you an edge or **adds to your health**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there **anything else** which may help us to understand you, your history, or your needs which have not been discussed on this survey? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

*Remember, health is a process. Past and present choices affect this process. Thank you for taking the time to provide us with the information we need to best help you achieve your health goals. Congratulations on taking an active step toward health and thank you for giving us the opportunity to participate in this process.*

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

HOW Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_