



PARTICIPANT REGISTRATION AND INTAKE FORM

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| | |
| Patient Initials/ Date | |

Participant History Form

Date of appointment ____/____/____ Time of appointment ____:____ am pm

Name _____

Birthdate: ____/____/____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact number: (____) _____ - _____ Home Cell Work

Alternate number: (____) _____ - _____ Home Cell Work

Email address: _____

Best days(s) and time(s) for appointments: _____

Best time of day to contact you: _____ Best method of contact: Home Email Cell Work

May we leave a message on your answering machine: Yes No

Emergency Contact Information:

Contact's Name _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact number: (____) _____ - _____ Home Cell Work

Alternate number: (____) _____ - _____ Home Cell Work

May we leave a message with this person: No Yes or Yes with Exclusions:

Primary Care Physician:

Name of Physician: _____ Phone: _____

Address: _____

Would you like your primary care physician notified of any clinical trials you participate in with MCRC?

Yes No

CLINIC USE ONLY

Date PCP letter sent: ____/____/____ N/A



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|------------------------|--|
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Sex: Male Female

Ethnicity: *(Check the box with who you most identify)*

- | | |
|--|--|
| <input type="checkbox"/> American Indian/Alaskan | <input type="checkbox"/> White |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other - Specify: |
| <input type="checkbox"/> Hispanic | |

Referred here by: *(Check one)*

- | | | | |
|--|---------------------------------|---------------------------------|---|
| <input type="checkbox"/> Self | <input type="checkbox"/> Family | <input type="checkbox"/> Friend | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> Physician, other: _____ | | | |
| <input type="checkbox"/> Health Professional, other: _____ | | | |

Current Symptoms of Disease and Medical History:

What is the primary reason for your visit today:

Date your symptoms began (approximate): ____/____/____

Date you started being treated for this diagnosis: ____/____/____

Treatments you have received or are currently receiving for this diagnosis?

Who have you seen for treatment?

*****For Medication and Medical History if unsure of start/ onset date, please provide your best estimate.**

| Current Medications | Dose | Reason for Use | Date Started |
|---------------------|------|----------------|--------------|
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Please check the box under “medical history” if you have ever been diagnosed with any of the following. If you are currently taking any medication for that condition check the box for “taking medication”. We understand it may be hard to remember the exact date the condition started. If necessary, please estimated as closely as possible the year of diagnoses.



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| Medical History | Condition | Start Date | Stop Date <i>(Check N/A if ongoing)</i> | Medical History | Condition | Start Date | Stop Date <i>(Check N/A if ongoing)</i> |
|--|--|------------|--|--------------------------|---|------------|--|
| AUTOIMMUNE DISEASE <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | |
| <input type="checkbox"/> | Sjogren's Syndrome | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Sub-acute Cutaneous Lupus erythematosus | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Psoriatic Arthritis | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Systemic Lupus erythematosus | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Rheumatoid Arthritis | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Giant Cell Arteritis | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Discoid Lupus erythematosus | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | |
| <input type="checkbox"/> | HIV Positive | | <input type="checkbox"/> N/A | <input type="checkbox"/> | | | <input type="checkbox"/> N/A |
| BLOOD DISORDER <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | |
| <input type="checkbox"/> | Anemia | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Leukopenia | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Thrombocytopenia (decreased platelets) | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | <input type="checkbox"/> N/A |
| CANCER/MALIGNANCY <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | |
| <input type="checkbox"/> | Type: | | | | | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Type: | | | | | | <input type="checkbox"/> N/A |
| CARDIOVASCULAR <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | |
| <input type="checkbox"/> | Arrhythmia/ Abnormal ECG (specify): | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Myocardial Infarction (heart attack) | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Angina (chest pain) | | <input type="checkbox"/> N/A | <input type="checkbox"/> | High cholesterol | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Congestive Heart Failure | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Hyperlipidemia | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Coronary Artery Disease | | <input type="checkbox"/> N/A | <input type="checkbox"/> | High blood pressure | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Carotid Stenosis | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | |
| <input type="checkbox"/> | Heart Murmur | | <input type="checkbox"/> N/A | <input type="checkbox"/> | | | <input type="checkbox"/> N/A |
| EARS <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | |
| <input type="checkbox"/> | Vertigo | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Hearing Disorder | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Hearing Loss (specify location) | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | <input type="checkbox"/> N/A |



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|---|---|------------|--|--------------------------|-----------------------------|------------|--|
| ENDOCRINE/METABOLIC <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | |
| <input type="checkbox"/> | Diabetes Type I | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Hashimoto's Thyroiditis | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Diabetes Type II | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Hyperthyroidism | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Cushing's Syndrome | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Hypothyroidism | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Adrenal Suppression | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Vitamin D Deficiency | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Iron Deficiency | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | <input type="checkbox"/> N/A |
| EYES <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | |
| <input type="checkbox"/> | Astigmatism | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Myopia (nearsightedness) | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Cataract (vision disturbance) | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Uveitis | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Hyperopia (farsightedness) | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Episcleritis | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Dry eyes | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Amaurosis Fugax | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Glaucoma | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Macular Degeneration | | <input type="checkbox"/> N/A |
| GASTROINTESTINAL <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | |
| <input type="checkbox"/> | Hemorrhoids | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Gastrointestinal Bleeding | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Blood in Stool | | <input type="checkbox"/> N/A | <input type="checkbox"/> | GERD | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Cholecystitis | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Heartburn | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Cholelithiasis (gallstones) | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Acid Reflux | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Chronic Constipation | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Hepatitis (specify type): | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Chronic Diarrhea | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Hernia (specify location): | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Chronic Vomiting | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Fatty Liver | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Diverticulitis | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Irritable Bowel Syndrome | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Elevated Liver Enzymes | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Nausea | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Inflammatory Bowel Disease (specify type) | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Recurrent Abdominal Pain | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Gastric Ulceration (specify type) | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | <input type="checkbox"/> N/A |



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|--|--|------------|--|--------------------------|--|--------------------------|--|--|------------------------------|
| GENITOURINARY <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | | | |
| <input type="checkbox"/> | Benign Prostatic Hyperplasia (BPH) | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Chronic Renal Disease | | <input type="checkbox"/> N/A | | |
| <input type="checkbox"/> | Herpes Simplex Type 2 (genital) | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Incontinence | | <input type="checkbox"/> N/A | | |
| <input type="checkbox"/> | Chronic Hematuria | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Kidney Stone | | <input type="checkbox"/> N/A | | |
| <input type="checkbox"/> | Erectile Dysfunction | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | | | |
| <input type="checkbox"/> | Sexually Transmitted Disease (specify type): | | <input type="checkbox"/> N/A | | | | <input type="checkbox"/> N/A | | |
| GYNECOLOGICAL <input type="checkbox"/> <i>No conditions reported</i> <input type="checkbox"/> N/A – Male | | | | | | | | | |
| <input type="checkbox"/> | Abnormal Mammogram | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Hot Flashes | | <input type="checkbox"/> N/A | | |
| <input type="checkbox"/> | Breast Cysts | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Irregular Menstrual Cycle | | <input type="checkbox"/> N/A | | |
| <input type="checkbox"/> | Breast Lumps | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | <input type="checkbox"/> N/A | | |
| INTEGUMENTARY <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | | | |
| <input type="checkbox"/> | Acne | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Psoriasis | | <input type="checkbox"/> N/A | | |
| <input type="checkbox"/> | Atopic Dermatitis | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Recurrent Rashes | | <input type="checkbox"/> N/A | | |
| <input type="checkbox"/> | Eczema | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Rosacea | | <input type="checkbox"/> N/A | | |
| <input type="checkbox"/> | Herpes Simplex Type 1 (cold sores) | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | | | |
| <input type="checkbox"/> | Herpes Zoster (Shingles) | | <input type="checkbox"/> N/A | | | | <input type="checkbox"/> N/A | | |
| MUSCULOSKELETAL <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | | | |
| <input type="checkbox"/> | Fibromyalgia | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Carpal Tunnel Syndrome (specify location): | | | | |
| <input type="checkbox"/> | Fractured Bones | | <input type="checkbox"/> N/A | | | | <input type="checkbox"/> N/A | | |
| <input type="checkbox"/> | Gout | | <input type="checkbox"/> N/A | | | <input type="checkbox"/> | Osteoporosis | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Leg Cramps | | <input type="checkbox"/> N/A | | | <input type="checkbox"/> | Recurrent Back Pain | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Osteoarthritis | | <input type="checkbox"/> N/A | | | <input type="checkbox"/> | Recurrent Joint Pain | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Osteopenia | | <input type="checkbox"/> N/A | | | <input type="checkbox"/> | Other: | | <input type="checkbox"/> N/A |



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|--|--|------------|--|--------------------------|---------------------------------|------------|--|
| NOSE or THROAT <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | |
| <input type="checkbox"/> | Seasonal Allergies | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Nasal Congestion | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Deviated Septum | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Sinus Congestion | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Nose Bleeds | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | <input type="checkbox"/> N/A |
| NEUROLOGICAL <input type="checkbox"/> <i>No conditions reported</i> | | | | | | | |
| <input type="checkbox"/> | Cerebral Accident/ Stroke (specify type): | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Seizures (specify type): | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Transient Ischaemic Attack | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Tingling (specify location): | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Diabetic Neuropathy | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Multiple Sclerosis | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Insomnia | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Numbness (specify location) | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Migraines | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Paralysis (specify location) | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Headaches (specify type) | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Parkinson's Disease | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Dizziness | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Tremors | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Lightheadedness | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Epilepsy | | <input type="checkbox"/> N/A | <input type="checkbox"/> | | | <input type="checkbox"/> N/A |
| PSYCHOLOGICAL <input type="checkbox"/> <i>No conditions</i> | | | | | | | |
| <input type="checkbox"/> | Alzheimer's Disease | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Substance Abuse (specify) | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Anxiety | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Panic attacks | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Bipolar Disorder | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Psychotic Episodes | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Dementia | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Schizophrenia | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Depression | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Eating Disorder | | <input type="checkbox"/> N/A | <input type="checkbox"/> | | | <input type="checkbox"/> N/A |



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|--|---|--------------------|--|--------------------------|----------------------------------|----------------------|--|
| RESPIRATORY <input type="checkbox"/> No conditions reported | | | | | | | |
| <input type="checkbox"/> | Asthma | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Pneumonia | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Interstitial Lung Disease | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Shortness of Breath | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Chronic Cough | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Sleep Apnea | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | COPD | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | |
| <input type="checkbox"/> | Tuberculosis | | <input type="checkbox"/> N/A | | | | <input type="checkbox"/> N/A |
| CHRONIC INFECTIONS <input type="checkbox"/> No conditions | | | | | | | |
| <input type="checkbox"/> | Chronic Ear Infections | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Chronic Eye Infections | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Chronic Yeast infections | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Chronic fungal infections | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Chronic Respiratory Infection/ Bronchitis | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Chronic Kidney Infection | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Chronic Bladder Infection | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Chronic Vaginal Infection | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Chronic Throat Infections | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Chronic Urinary Tract Infections | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Chronic Sinus Infections | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | <input type="checkbox"/> N/A |
| GENERAL/ OTHER <input type="checkbox"/> No conditions reported | | | | | | | |
| <input type="checkbox"/> | Obesity | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Raynaud's Phenomenon | | <input type="checkbox"/> N/A |
| <input type="checkbox"/> | Other: | | <input type="checkbox"/> N/A | <input type="checkbox"/> | Other: | | <input type="checkbox"/> N/A |
| REPRODUCTIVE STATUS <input type="checkbox"/> No conditions reported | | | | | | | |
| Is patient of non-childbearing potential or a sterilized male? Yes <input type="checkbox"/> No <input type="checkbox"/> * (see below) <small>(post-menopausal ≥ 1yr or post vasectomy ≥6 mo or hysterectomy, ooperectomy or tubal ligation)</small> If "No", indicate the form of birth control currently used: _____ | | | | | | | |
| <input type="checkbox"/> | Bi-lateral Oophorectomy | Date of procedure: | | <input type="checkbox"/> | Tubal Ligation | Date of procedure: | |
| <input type="checkbox"/> | Vasectomy with confirmation (MALES ONLY) | Date of procedure: | | <input type="checkbox"/> | Post-Menopausal | Date of last period: | |
| | | | | <input type="checkbox"/> | Hysterectomy | Date of procedure: | |



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VACCINATION HISTORY

| | | |
|--------------------------|----------------------|----------------|
| <input type="checkbox"/> | BCG (TB Vaccination) | Received Date: |
| <input type="checkbox"/> | Pneumovax | Received Date: |
| <input type="checkbox"/> | Flu | Received Date: |
| <input type="checkbox"/> | Other: | Received Date: |

| ALLERGY | REACTION | DATE |
|---------|----------|------|
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| S | SURGERY/ HOSPITALIZATION (Check S for surgery in box to left) | REASON | DATE |
|--------------------------|--|--------|------|
| <input type="checkbox"/> | | | |
| <input type="checkbox"/> | | | |
| <input type="checkbox"/> | | | |
| <input type="checkbox"/> | | | |
| <input type="checkbox"/> | | | |
| <input type="checkbox"/> | | | |
| <input type="checkbox"/> | | | |

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| I have reviewed the information in the patient's intake form in full, discussed the information with the patient, and clarified information in a research chart note as necessary. | |
| Coordinator Signature _____ | Date _____ |
| Investigator Signature _____ | Date _____ |