**** 3050 W 151St Ct.

 Suite 100

 Broomfield, CO 80023

www.aboundinghope.life

 (303) 494-3116 Office

**History Intake**

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

**Age:\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M\_\_\_ F\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies:** Environnemental Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Drug Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Food Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Allergy to Alcohol? \_\_\_\_YES \_\_\_\_NO

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| **CURRENT HEALTH PROBLEMS** (List in order of importance, most important first) | Month & Year started |
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| **MAIN COMPLAINT** (please describe in some details) |
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**Are you taking immunosuppressant drugs (steroids, many arthritis drugs, etc.)?**

 \_\_\_\_YES \_\_\_\_NO If so, what one(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you on blood thinners or have bleeding tendencies?**

\_\_\_\_YES \_\_\_\_NO If so, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had a blood transfusion or organ transplant?**

 \_\_\_\_YES \_\_\_\_NO If so, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a pacemaker or hearing aids?**

 \_\_\_\_YES \_\_\_\_NO If so, which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you on birth control (pill, IUD – copper or plastic, implant, patch, ring, shot, etc.)?**

 \_\_\_\_YES \_\_\_\_NO If so, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had a hysterectomy (full or partial)?**

 \_\_\_\_YES \_\_\_\_NO If so, which type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any fillings in your teeth (amalgam, gold, porcelain, composite, resin or glass ionomer)?**

 \_\_\_\_YES \_\_\_\_NO If so, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any artificial body parts/reparative devices (stents, screws, wire, knees, hips, breast augmentation, teeth implants, mesh, metal plates, etc.)?**

 \_\_\_\_YES \_\_\_\_NO If so, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had a Barium enema or a Barium drink for medical testing purposes?**

 \_\_\_\_YES \_\_\_\_NO If so, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been diagnosed with diabetes (pre, type 1 or 2, GDM, or diabetes insipidus)?**

 \_\_\_\_YES \_\_\_\_NO If so, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any concussions?**

 \_\_\_\_YES \_\_\_\_NO If so, how many and approximate dates? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you suffer with any addictions?**

 \_\_\_\_YES \_\_\_\_NO

**Do you currently or have you ever used any of the following: Tobacco (chew/cigarette), cigar, marijuana, etc.?**

 \_\_\_\_YES \_\_\_\_NO If so, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did you have typical childhood vaccines?**

 \_\_\_\_YES \_\_\_\_NO

**How often do you get/have you had flu vaccines?**

 \_\_\_\_NEVER \_\_\_\_RARELY \_\_\_\_EVERY FEW YEARS \_\_\_\_YEARLY

**Have you had any other vaccine boosters in the last 10-15 years (pneumococcal, Tdap, chicken pox, shingles, Hepatitis, others)?**

 \_\_\_\_YES \_\_\_\_NO If so, which one(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Symptoms** | **Frequency** | **Severity** |
| **Highlight or Star (\*)** the five symptoms that bother you most. | **DAILY** | **FEW DAYS/WEEK** | **OCCASIONALLY** | **RARELY** | **PAST SYMPTOM** | **1** | **2** | **3** | **4** | **5** |
| **Severity:** 1 = mild / 5 = severe & intolerable |
| Please note: SOME LINES HAVE MULTIPLE SYMPTOMS. PLEASE MAKE CLEAR WHICH ONE(S) APPLY TO YOU ON THAT LINE by underlining, |
| **Bolding**, or circling. |
| **Head, Face, Neck** |   |   |   |   |   |   |   |   |   |   |
|          Unexplained hair loss |  |  |  |  |  |  |  |  |  |  |
|          Headache, mild or severe, seizures |  |  |  |  |  |  |  |  |  |  |
|          Migraine, migraine with aura |  |  |  |  |  |  |  |  |  |  |
|          Pressure in head, white matter lesions in brain (MRI) |  |  |  |  |  |  |  |  |  |  |
|          Twitching of facial or other muscles |  |  |  |  |  |  |  |  |  |  |
|          Facial paralysis (Bell’s Palsy, Horner’s syndrome) |  |  |  |  |  |  |  |  |  |  |
|          Tingling of nose, (tip of) tongue, cheek or facial flushing |  |  |  |  |  |  |  |  |  |  |
|          Stiff or painful neck |  |  |  |  |  |  |  |  |  |  |
|          Jaw pain or stiffness |  |  |  |  |  |  |  |  |  |  |
|          Dental problems |  |  |  |  |  |  |  |  |  |  |
|          Sore throat, clearing throat, phlegm, or hoarseness |  |  |  |  |  |  |  |  |  |  |
|          Runny nose or Sinus issues |  |  |  |  |  |  |  |  |  |  |
|          Dry eyes, dry mouth |  |  |  |  |  |  |  |  |  |  |
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| **Eyes/Vision** |  |  |  |  |  |  |  |  |  |  |
|          Double or blurry vision |  |  |  |  |  |  |  |  |  |  |
|          Increased floating spots |  |  |  |  |  |  |  |  |  |  |
|          Pain in eyes, or swelling around eyes |  |  |  |  |  |  |  |  |  |  |
|          Oversensitivity to light |  |  |  |  |  |  |  |  |  |  |
|          Flashing lights, peripheral waves, phantom images in corner of eyes |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Ears/Hearing** |  |  |  |  |  |  |  |  |  |  |
|          Decreased hearing in one or both ears, plugged ears |  |  |  |  |  |  |  |  |  |  |
|          Buzzing in ears or Ringing in one or both ears |  |  |  |  |  |  |  |  |  |  |
|          Pain in ears, oversensitivity to sounds |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Musculoskeletal System** |  |  |  |  |  |  |  |  |  |  |
|          Bone or back pain, joint pain or swelling, carpal tunnel |  |  |  |  |  |  |  |  |  |  |
|          Stiffness of joints, back, neck, tennis elbow |  |  |  |  |  |  |  |  |  |  |
|          Muscle pain or cramps, (Fibromyalgia) |  |  |  |  |  |  |  |  |  |  |
|          Gout |  |  |  |  |  |  |  |  |  |  |
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| **Symptoms** | **Frequency** | **Severity** |
|  | **DAILY** | **FEW DAYS/WEEK** | **OCCASIONALLY** | **RARELY** | **PAST SYMPTOM** | **1** | **2** | **3** | **4** | **5** |
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|  |
| 1 = mild / 5 = severe & intolerable |
| **Integument (Skin) System** |  |  |  |  |  |  |  |  |  |  |
|          Rash, bullseye or other |  |  |  |  |  |  |  |  |  |  |
|          Unexplained Hives |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Digestive and Excretory Systems** |   |   |   |   |   |   |   |   |   |   |
|          Diarrhea |  |  |  |  |  |  |  |  |  |  |
|          Constipation |  |  |  |  |  |  |  |  |  |  |
|          Hemorrhoids |  |  |  |  |  |  |  |  |  |  |
|          Irritable bladder (trouble starting, stopping), interstitial cystitis, or UTI-like symptoms |  |  |  |  |  |  |  |  |  |  |
|          Irritable bowel (IBS), intestinal cramping, bloating |  |  |  |  |  |  |  |  |  |  |
|          Upset stomach (nausea or pain) or GERD/acid reflux  |  |  |  |  |  |  |  |  |  |  |
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| **Respiratory and Circulatory Systems** |  |  |  |  |  |  |  |  |  |  |
|          Shortness of breath, can’t get full/satisfying breath |  |  |  |  |  |  |  |  |  |  |
|         Asthma |  |  |  |  |  |  |  |  |  |  |
|         Cough |  |  |  |  |  |  |  |  |  |  |
|          Chest pain or rib soreness |  |  |  |  |  |  |  |  |  |  |
|          Night sweats or unexplained chills |  |  |  |  |  |  |  |  |  |  |
|          Heart palpitations or extra beats |  |  |  |  |  |  |  |  |  |  |
|          High Blood Pressure or Low Blood Pressure |  |  |  |  |  |  |  |  |  |  |
|          Endocarditis, heart blockage |  |  |  |  |  |  |  |  |  |  |
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| **Neurologic System** |  |  |  |  |  |  |  |  |  |  |
|          Tremors or unexplained shaking |  |  |  |  |  |  |  |  |  |  |
|          Burning or stabbing sensations in the body |  |  |  |  |  |  |  |  |  |  |
|          Fatigue, Chronic Fatigue Syndrome |  |  |  |  |  |  |  |  |  |  |
|          Peripheral neuropathy or partial paralysis |  |  |  |  |  |  |  |  |  |  |
|          Weakness or loss of strength in hands or legs |  |  |  |  |  |  |  |  |  |  |
|          Pressure in the head |  |  |  |  |  |  |  |  |  |  |
|          Numbness in body, tingling, pinpricks |  |  |  |  |  |  |  |  |  |  |
|          Restless legs |  |  |  |  |  |  |  |  |  |  |
|          Poor balance, dizziness, difficulty walking |  |  |  |  |  |  |  |  |  |  |
|          Increased motion sickness |  |  |  |  |  |  |  |  |  |  |
|          Light-headedness, wooziness |  |  |  |  |  |  |  |  |  |  |
| **Symptoms** | **Frequency** | **Severity** |
|  | **DAILY** | **FEW DAYS/WEEK** | **OCCASIONALLY** | **RARELY** | **PAST SYMPTOM** | **1** | **2** | **3** | **4** | **5** |
|  |
|  |
| 1 = mild / 5 = severe & intolerable |
| **Psychological Well-being** |  |  |  |  |  |  |  |  |  |  |
|          Mood swings, irritability, bi-polar disorder |  |  |  |  |  |  |  |  |  |  |
|          Unusual depression |  |  |  |  |  |  |  |  |  |  |
|          Disorientation (getting or feeling lost) |  |  |  |  |  |  |  |  |  |  |
|          Feeling as if you are losing your mind |  |  |  |  |  |  |  |  |  |  |
|          Over-emotional reactions, crying easily |  |  |  |  |  |  |  |  |  |  |
|          Too much sleep, or insomnia |  |  |  |  |  |  |  |  |  |  |
|          Difficulty falling or staying asleep |  |  |  |  |  |  |  |  |  |  |
|          Narcolepsy, sleep apnea |  |  |  |  |  |  |  |  |  |  |
|          Panic attacks, anxiety, PTSD |  |  |  |  |  |  |  |  |  |  |
|          OCD, ADD, ADHD |  |  |  |  |  |  |  |  |  |  |
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| **Mental Capability** |  |  |  |  |  |  |  |  |  |  |
|          Memory loss (short or long term) |  |  |  |  |  |  |  |  |  |  |
|          Confusion, difficulty thinking |  |  |  |  |  |  |  |  |  |  |
|          Difficulty with concentration |  |  |  |  |  |  |  |  |  |  |
|          Difficulty with reading |  |  |  |  |  |  |  |  |  |  |
|          Going to the wrong place |  |  |  |  |  |  |  |  |  |  |
|          Speech difficulty (slurred or slow) |  |  |  |  |  |  |  |  |  |  |
|          Difficulty finding commonly used words |  |  |  |  |  |  |  |  |  |  |
|          Stammering speech |  |  |  |  |  |  |  |  |  |  |
|          Forgetting how to perform simple tasks |  |  |  |  |  |  |  |  |  |  |
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| **Reproduction and Sexuality** |   |   |   |   |   |   |   |   |   |   |
|          Loss of sex drive |  |  |  |  |  |  |  |  |  |  |
|          Sexual dysfunction |  |  |  |  |  |  |  |  |  |  |
|          Unexplained menstrual pain, irregularity |  |  |  |  |  |  |  |  |  |  |
|          Unexplained breast pain, discharge |  |  |  |  |  |  |  |  |  |  |
|          Yeast Infections |  |  |  |  |  |  |  |  |  |  |
|          Testicular or pelvic pain |  |  |  |  |  |  |  |  |  |  |
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| **Symptoms** | **Frequency** | **Severity** |
|  | **DAILY** | **FEW DAYS/WEEK** | **OCCASIONALLY** | **RARELY** | **PAST SYMPTOM** | **1** | **2** | **3** | **4** | **5** |
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|  |
| 1 = mild / 5 = severe & intolerable |
| **General Well-being** |  |  |  |  |  |  |  |  |  |  |
|          Phantom smells |  |  |  |  |  |  |  |  |  |  |
|          Unexplained weight gain or loss |  |  |  |  |  |  |  |  |  |  |
|          Extreme fatigue |  |  |  |  |  |  |  |  |  |  |
|          Swollen glands or lymph nodes |  |  |  |  |  |  |  |  |  |  |
|          Unexplained fevers (high or low grade) |  |  |  |  |  |  |  |  |  |  |
|          Continual infections (sinus, kidney, eye, etc.) |  |  |  |  |  |  |  |  |  |  |
|          Symptoms seem to change, come and go |  |  |  |  |  |  |  |  |  |  |
|          Pain migrates (moves) to different body parts |  |  |  |  |  |  |  |  |  |  |
|          Low body temperature |  |  |  |  |  |  |  |  |  |  |
|          Allergies or chemical sensitivities |  |  |  |  |  |  |  |  |  |  |
|          Increased effect from alcohol and possible worse hangover |  |  |  |  |  |  |  |  |  |  |
|          Early on, experienced a “flu-like” illness, after which you have not felt well. |  |  |  |  |  |  |
|  If yes, mark “past symptom” and severity) |  |  |  |  |  |  |
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| **Additional Symptoms** |  |  |  |  |  |  |  |  |  |  |
|          Psoriasis |  |  |  |  |  |  |  |  |  |  |
|          Vitiligo |  |  |  |  |  |  |  |  |  |  |
|          Warts |  |  |  |  |  |  |  |  |  |  |
|          Dry skin, dandruff |  |  |  |  |  |  |  |  |  |  |
|          Dark circles under eyes |  |  |  |  |  |  |  |  |  |  |
|          Negative reactions to vaccines |  |  |  |  |  |  |  |  |  |  |
|          Flatulence |  |  |  |  |  |  |  |  |  |  |
|          Poor skin integrity |  |  |  |  |  |  |  |  |  |  |
|          Excessive snoring |  |  |  |  |  |  |  |  |  |  |
|          Brittle nails |  |  |  |  |  |  |  |  |  |  |
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| **Other** |  |  |  |  |  |  |  |  |  |  |
|          |  |  |  |  |  |  |  |  |  |  |
|           |  |  |  |  |  |  |  |  |  |  |
|           |  |  |  |  |  |  |  |  |  |  |

**If complaining of pain, how do you describe your pain?**

**Does the pain refer or radiate to other places? Does it change or come and go?** Please explain

**What factors worsen your pain?**

**What factors decrease your pain?**

**Is your pain resulting from an accident?**

 \_\_\_\_YES \_\_\_\_NO If so, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Diagnoses received to date:** |
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| List investigations done so far and their results:* MRI
* CT Scan
* X-Ray
* Endoscopy
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| **Treatment received up-to-date for your current problem(s):**  |
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| **List all *CURRENT* medications and supplements:** |
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| **List all *PAST* medications and supplements:** |
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**Check or highlight all treatment received in the past or being currently received:**

* Bed rest
* Traction
* Nerve blocks
* Exercise
* Hypnosis
* Chiropractor
* Pharmaceuticals
* Chemotherapy
* Radiation
* Electrical stimulation
* Surgery
* Acupuncture
* Epidural blocks
* Heat treatment
* Physical Therapy
* Supplements
* Other

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| **List of all Surgical Operations** | **Year Performed** |
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| **List of Cancer Diagnoses and Treatments** | **Year Diagnosed** |
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| **Other States and Countries *Traveled To* (Important)** | **Approximate Dates of Travel (year )** |
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| **Other State and Countries *Lived In* (Important)** | **Years** |
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**Daily Habits (E.g. walking/exercising; smoking; daily alcoholic drink, coffee, soda; computer; TV, etc.)**

**Past & Present Hobbies Please list all you can think of. This information is used to determine exposure. (E.g. fishing, hunting, stained glass, painting, reading, gardening, welding, building things, auto repair, etc.)**

**Family History of Illnesses (Please *also* indicate where family member lived just before/during illness)**

**Are you (or have you ever been) on well water?** \_\_\_\_YES \_\_\_\_NO

**Do you live under or very close to high voltage power lines?** \_\_\_\_YES \_\_\_\_NO

**Do you or have you ever lived near a nuclear power plant/radiation zone?** \_\_\_\_YES \_\_\_\_NO

**Do you have or have you ever had pets?**

\_\_\_\_YES \_\_\_\_NO **If so, what type?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have you ever been bitten by a tick that you are aware of?**

\_\_\_\_YES \_\_\_\_NO **If so, where were you (State/Country) when this occurred and what was the approximate year? \_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Employment - *Where you worked and what you did*. (Important) This helps determine potential exposure to toxins, pathogens, etc.** | **Approximate Dates by Year** |
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**Thank you! I know this is long, but it will save time on exam day and will assist in a more thorough exam.**