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**Informed Consent for Treatment** TO THE PATIENT or Client: You have the right, as a patient or client, to be informed about your condition and the recommended diagnostic, physical therapy or rehabilitation treatment/procedure to be used so that you may make the decision whether or not to undergo the treatment/procedure after knowing the risks and hazards involved. This disclosure is an effort to make you better informed so you may give or withhold your consent to the treatment/procedure. I (we) voluntarily request **SLS Therapy, PLLC/Silvey Consulting** its physical therapists, and such associates, trainers, technical assistants and other health care providers as they may deem necessary, do an evaluation, or give advice/education or with proper referrals to treat my condition which has been explained to me. I (we) understand that the following physical therapy or rehabilitation evaluation, advice or treatment / procedures are planned for me and I (we) voluntarily consent and authorize these procedures. I (we) understand that my physical therapist may discover other or different conditions which require additional or different procedures than those planned and may require consent from my physician before such additional or different procedures are utilized. I (we) authorize my physical therapist, and such associates, technical assistants and other health care providers with consent from my physician to perform such other procedures which are advisable in their professional judgment. I (we) understand that no warranty or guarantee has been made to me as to result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the diagnostic, physical therapy, or rehabilitation treatment / procedures planned for me. I (we) realize that common to diagnostic, physical therapy, or rehabilitation treatment/ procedures is the potential risk for such procedures and treatment to cause side effects, pain, or other problems. I certify that the information I have provided is complete and true to the best of my knowledge. I give my authorization for treatment records to be released to the responsible payor for reimbursement consideration, or medical facility necessary for treatment or further care. Additionally, I request that any medical records requested by this facility, necessary for treatment or further care, be forwarded to this facility upon its request. I understand that I am financially responsible for all charges whether or not paid for by said insurance (i.e. deductible amounts, co-insurance, co-pay, or any other balance not paid by my insurance). If this account is assigned to an attorney for collection and/or suit, the facility shall be entitled to reasonable attorney’s fees and costs of collection. I request that payment of authorized benefits be made on my behalf to this facility. I assign the benefits payable to which I am entitled to this facility for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy and/or facsimile of this assignment is to be considered as valid as an original. I have received a copy of the Notice of Privacy Practices for SLS Therapy, PLLC. We reserve the right to modify any privacy practices outlined. I have read the foregoing and I understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction. COMPLETE IF OVER THE AGE OF 18 YEARS OF AGE: The undersigned, being over the age of eighteen (18) years and being under no disability or prohibition that would in any way prevent or affect the Consent and Release, does hereby represent that, I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(CLIENT), consent to an evaluation, advice/education or rehabilitation treatment as prescribed by my provider. Signature Date COMPLETE IF THE CLIENT IS A MINOR OR WHEN THE ADULT CLIENT IS NOT COMPETENT: In the treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MINOR/ADULT CIENT), I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, client representative of said minor/adult, consent to an evaluation, advice or rehabilitation treatment as prescribed by minor’s/adult’s provider. My relationship to the client is (i.e. parent, son, daughter, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Signature of Parent or legal guardian Date



**Medical/Family History Questionnaire**

**(PLEASE PRINT FORM, COMPLETE and BRING TO YOUR FIRST VISIT)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | **Patient/Client Name:** |  |  |  |  |  |  |  |  |  |  |  |  | **Date of Birth:** |  |  |  |  |  |  |  |  |  |  |  | **Sex: (circle)** |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **Male** | **Female** |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **Form Completed By:** |  |  |  | **Today’s Date** |  |  | **Relationship:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  **PREGNANCY/BIRTH HISTORY(if client is a minor )<16 yrs** |  |  |  |  | **SOCIAL HISTORY** |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **Who lives in household?** |  |  |  |  |  |  |  |  |  |  |
|  |  | **Illnesses during pregnancy?** |  | **No ☐** | **Yes ☐** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **Medications during pregnancy?** | **No ☐** | **Yes ☐** |  |  | **How many?** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **Alcohol/Drug Abuse?** |  | **No ☐** | **Yes ☐** |  |  | **☐ Rent?** | **☐ Own?** |  |  |  |  |  | **☐ Shelter?** |  |  |  |  |  |
|  |  | **Problems at birth?** |  |  |  | **No ☐** | **Yes ☐** |  |  | **Who cares for child?** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **Describe** |  |  |  |  |  |  |  |  |  |  |  |  |  | **Date of Birth?** |  |  |  |  | **Mother** |  |  |  |  |  |  |  |  |  |  |
|  |  | **Type of delivery?** | **☐ Vaginal** |  | **☐ C-section** |  |  |  |  |  |  |  |  |  | **Father** |  |  |  |  |  |  |  |  |  |  |
|  |  | **Birth Weight** |  |  |  |  |  |  |  | **Are parents working?** | **Mother** | **No** | **☐ Yes** | **☐** |  |
|  |  | **Did baby receive Hepatitis B vaccine?** | **No ☐ Yes ☐** |  |  |  |  |  |  |  |  |  |  | **Father** | **No** | **☐ Yes** | **☐** |  |
|  |  | **Date of Hepatitis B immunization:** |  |  |  |  |  |  |  |  | **Foster Care?** |  |  |  |  |  |  |  | **Dates:** |  |  |  |  |  |  |  |
|  |  | **Newborn Hearing Screen?** |  | **No ☐** | **Yes ☐** |  |  | **Other Languages?** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  | **FAMILY HISTORY** |  |  |  |  |  |  |  |  |  |  | **MEDICAL HISTORY** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **Has anyone in the family (parents, grand-parents,** |  |  | **Has your child ever had:** |  |  |  |  |  |  |  |  |  |
|  |  | **aunts/uncles, sisters/brothers) had:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  | **Who?** |  |  | **Allergies (List) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **No ☐** | **Yes ☐** |  |
|  |  | **Allergies (List) \_\_\_\_\_\_\_\_\_\_\_** | **No ☐** | **Yes ☐** |  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |  |  |
|  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |  |  |  |  |  |  | **Asthma** |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Asthma** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Chicken Pox (Year)** |  |  |  |  |  |  |  |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **TB/Lung Disease** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Frequent Ear Infections** |  |  |  |  |  |  |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **HIV/AIDS** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Vision/Hearing Problems** |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Suicide Attempts** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Skin Problems/Eczema** |  |  |  |  |  |  |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Heart Disease** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **TB/Lung Disease** |  |  |  |  |  |  |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **High Blood Pressure/Stroke** | **No ☐** | **Yes ☐** |  |  |  |  | **Seizures/Epilepsy** |  |  |  |  |  |  |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **High Cholesterol** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **High Blood Pressure** |  |  |  |  |  |  |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Blood Disorders/Sickle Cell** | **No ☐** | **Yes ☐** |  |  |  |  | **Heart Defects/Disease** |  |  |  |  |  |  |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Diabetes** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Liver Disease/Hepatitis** |  |  |  |  |  |  |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Seizures** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Diabetes** |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Mental Illness** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Kidney Disease/Bladder Infections** | **No ☐** | **Yes ☐** |  |
|  |  | **Cancer** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Physical or Learning Disabilities** |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Birth Defects** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Bleeding Disorders/Hemophilia** |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Hearing Loss** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Sexually Transmitted Diseases** |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Speech Problems** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Emotional or Behavioral Problems** | **No ☐** | **Yes ☐** |  |
|  |  | **Kidney Disease** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Depression/Suicidal Thoughts** |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Alcohol/Drug Abuse** |  |  | **No ☐** | **Yes ☐** |  |  | **Hospitalizations/Surgeries** |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Hepatitis/Liver Disease** |  |  |  |  |  |  |  |  |  |  | **Physical/Emotional/ Sexual Abuse** | **No ☐** | **Yes ☐** |  |
|  |  | **Thyroid Disease** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Bone or Joint Injuries** |  |  |  |  |  |  |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Learning Problems/Attention** | **No ☐** | **Yes ☐** |  |  |  |  | **Obesity/Eating Disorders** |  |  |  | **No ☐** | **Yes ☐** |  |
|  |  | **Deficit Disorder** |  |  | **No ☐** | **Yes ☐** |  |  |  |  | **Other:** |  |  |  |  |  |  | **\_\_\_** |  | **No ☐** | **Yes ☐** |  |
|  |  | **Family Violence** |  |  | **No ☐** | **Yes ☐** |  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |  |  |  |  |
|  |  | **Other:** |  |  |  |  |  |  |  |  |  |  |  |  | **Current Medication(s): (*List*)** |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | **Reviewed by:** |  |  |  |  |  |  |  |  |  |  |  |  | **Date of Review:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**PLEASE ANSWER ALL QUESTONS TO THE BEST OF YOUR ABILITY**

**(Please print, complete the form, and bring to your first visit)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Gender: \_\_\_\_

Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your main physical issue/concern that you would like to discuss today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please describe in **detail *when*** and ***how***your symptoms/issues started? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Do you have your symptoms(please circle one): ***every minute of the day, most of everyday*** or ***part of everyday***?
2. Please describe your symptoms using the words below. Circle all that apply.

Stabbing Burning Aching Sharp Numbness Pins/ Needles Stiffness Weakness Shooting Tingling

1. What activities, positions or postures make your symptoms **worse**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What do you normally do in order to make your symptoms **better** or less noticeable?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What is your pain level on a scale of 0-10? With activity:\_\_\_\_\_\_\_\_\_ At rest:\_\_\_\_\_\_\_\_\_\_\_

(1-3 mild pain 4-6 moderate pain 7-10 severe pain)

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1. Do you notice any symptoms that radiates into your arms from your **neck**?(circle one): Yes/No
2. Do you notice any symptoms that radiates into your arms from your **lower back**?(circle one): Yes/No
3. **PLOF**: Did you have any problems performing any of part of your normal daily routine before your symptoms began?(please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Please list **any** surgeries you have had and the **dates** of those surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Please list **any** medical conditions you currently have( if different from the medical history questionnaire):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please list **any** known medical conditions that your **mother** or **father** had or currently have( if different from the medical history questionnaire):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. If you are taking medications or health supplements related please list it here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. If you are taking medication for **pain/inflammation** what percentage of relief do you receive? (100% relief would represent complete elimination of your symptoms):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Do you feel you have sleep problems due to your symptoms? Please circle: **YES** /**NO**
6. Please list the daily activities that you **avoid or modify** because of your symptoms/issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
7. What is your Occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. What are your primary responsibilities at work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. How would you rate your **overall** health? (Circle one)

 Poor Fair Good Great Excellent

**What would you like to be able to do in 30 days that you are unable to do right now?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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