**Client Information/Adolescent Intake and Assessment (14-17 yrs)**

*(Adolescent may need an adult to assistance for some of the questions)*

Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Identification:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

Nicknames or aliases: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents’ Names\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/Evening phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave our name when calling or e-mailing? \_\_\_\_\_\_\_\_

Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best number to reach you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Dr. Donna Martin Psy.D?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Do you give us permission to thank this person for the referral? ❑ Yes ❑ No

**Religious and racial/ethnic identification:**

Religious affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu ❑ Other

Involvement: ❑ None ❑ Some/irregular ❑ Active

Ethnicity/National origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal History:**

Are required by a court, the police, or a probation/parole officer to have this appointment? ❑ Yes ❑ No

Are you in any other legal involvements? ❑ Yes ❑ No

**Your Current Employer:**

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Education:**

|  |  |  |  |
| --- | --- | --- | --- |
| Grade | School | Special Classes | Grade Average |
|  |  |  |  |

Are there any changes in your grades? ❑ Yes ❑ No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Favorite subject\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Most difficult subject\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activities in school\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any behavior problems in school? ❑ Yes ❑ No

Do you get along with your teachers? ❑ Yes ❑ No

Have you ever been bullied? ❑Yes ❑ No

Describe any other concerns about school:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family:**

**Family members:** (Living in your household)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How Are They Related | Name | Current Age | Health Issues Or Other Concerns | Their Education | Their Occupation |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |

Do you spend time living anywhere else? ❑Yes ❑ No

**Present Relationships**

Are you currently having problems with any parent/step-parent/guardian? ❑Yes ❑ No

Are you currently having problems with siblings/step-siblings? ❑Yes ❑ No

Is there a history of mental health, drugs or alcohol problems in your family? ❑Yes ❑ No

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Sexual Orientation:** ❑Heterosexual❑Bisexual❑Gay/Lesbian❑Questioning

**Relationship status:** ❑Single❑In a RelationshipHow long**\_\_\_\_\_\_\_\_\_\_\_**

**Other Relationships:**

Are you currently having problems in your relationships with your friends? ❑Yes ❑ No

Circle activities that you are involved in

Sports Church Social media

Music Youth groups Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Video games Arts/Crafts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Computers Ipod/tablets/cell phone

**Health Habits**

Do you engage in physical exercise? ❑ Yes ❑ No

Do you or your parents have any concerns about your eating behavior? ❑ Yes ❑ No

If yes, please explain:

How?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Why?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have any problems getting enough sleep? ❑ Yes ❑ No

Do you have problems staying asleep? ❑ Yes ❑ No

**Brief Health History Form:**

Date of last physical exam**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Was blood work done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Starting with infancy and up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age | Illness/Diagnosis | Treatment Received | Treated By | Result |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

List and describe any allergies (drug and other) you have.

|  |  |
| --- | --- |
| Allergies | Reactions |
|  |  |
|  |  |

List *all* medications, drugs, or other substances (other than psychiatric) you take or have taken in the last year: prescribed, over-the-counter medications, vitamins, herbs, and others. (Provide separate page if needed)

|  |  |  |  |
| --- | --- | --- | --- |
| Medication/Drug | Dose | Reason For Taking | Prescribed By |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you been exposed to toxic chemicals? ❑ Yes ❑ No

**Mental Health Treatment History:**

Have you ever or are you presently receiving psychological, psychiatric, or counseling services? ❑ Yes ❑ No

If yes, list ALL psychological, psychiatric, or counseling services received, including past and present treatments.

|  |  |  |  |
| --- | --- | --- | --- |
| Date | From Whom | For What | Results |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you ever or are you presently taking medications for psychiatric or

emotional/behavioral problems? ❑ Yes ❑ No

If yes, please list ALL medications for psychiatric or emotional problems

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medications | Date | Prescribed By | For | Results | Still Taking |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

(Attach additional paper if needed)

**Screenings/Assessments:**

**Abuse History:**

❑ I was not abused in any way. ❑ I was abused.

This will be discussed further during intake.

**Symptoms (In the past 30 Days)**

**Circle any Incidence of:**

|  |  |
| --- | --- |
| 1. Sad, depressed mood | 1. Crying frequently |
| 1. Lost interest in play | 1. Not sleeping or sleeping too much |
| 1. Change in eating pattern | 1. Poor Focus or concentration |
| 1. Feeling of guilt or worthlessness | 1. Feeling of helplessness or hopelessness |
| 1. Thoughts or talk of death or suicide | 1. Lack of energy |
| 1. Thoughts or talk of hurting or killing someone else |  |

Mood swings: Alternating depression "sad" and euphoric "manic" ❑Yes❑No

Elevated mood: Highly talkative, flight of ideas, agitated ❑Yes❑No

Panic attack: Intense fear or discomfort, racing heart, trembling for no reason ❑Yes❑No

Anxiety/Phobia that is excessive and unreasonable: it may include excessive worrying ❑Yes❑No

Verbal anger/Rage ❑Yes❑No

Explosive outbursts or acting violent ❑Yes❑No

Compulsive behavior ❑Yes❑No

Intrusive thoughts ❑Yes❑No

Problems with attention and focus ❑Yes❑No

Problems completing tasks ❑Yes❑No

Frequently losing or misplacing things ❑Yes❑No

Interrupting others in conversation ❑Yes❑No

Following rules ❑Yes❑No

History of suicide attempts ❑Yes❑No

History of any other self-harming behaviors (i.e.cutting) ❑Yes❑No

Hair pulling/Skin picking ❑Yes❑No

Are there weapons in your home? ❑Yes❑No

**Drug/Alcohol Use:**

**Alcohol use:**

Do you drink alcohol? ❑Yes❑No

How many alcoholic drinks do you have in a typical week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you are a “normal” drinker ❑Yes❑No

(“normal” = drink as much or less than other people your age)

**Drug use:**

Do you believe you have a drug problem? ❑Yes❑No

List all illegal drugs or medications not prescribed for you that you have used in the past month.

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

List all illegal drugs or medications not prescribed for you that you have used in your lifetime.

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

Have you ever used inhalants (“huffing”), such as glue, gasoline, or paint thinner? ❑Yes❑No

**Physical Health Concerns:**

How many cups of regular coffee do you drink each day? \_\_\_\_\_\_\_\_ How many cups of tea? \_\_\_\_\_\_ How many sodas with caffeine (Coke, Pepsi, Mountain Dew, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_ How many “energy drinks”? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other caffeine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a nicotine user? ❑ No ❑ Yes Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For girls only:**

1. What age did you start to menstruate (get your period): \_\_\_\_\_\_\_

2. Menstrual period experiences:

a. How regular are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. How long do they last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. How much pain do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. How heavy are your periods?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e. Other experiences during periods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chief Concern/Problem:**  
What is the main reason you are here to see me: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe anything else that is important for me to know

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