Bienvenidos!

Por favor tomen unos minutos para completar el cuestionario. Si tiene alguna pregunta les podimos ayudar. Estamos contentos de podar ayudartes con su salud.

Informacion de Paciente

Nombre: _____ Seguro Social: _____
Apeido Primer Nombre Inicial

Direccion: _____

Ciudad: _____ Estado: _____ Codigo Postal: _____
Numero de Telefono : _____ Celular: _____
Correo Electronico : _____
Sexo ☐ M ☐ F Edad _____ Fecha de Nacimiento : _____
☐ Soltero ☐ Casado ☐ Divorciado ☐ Viuda ☐.Sparado
Nombre de Epleador _____ Ocupacion _____
Domicilio de Trabajo _____
Numero deTelefono de Emlpleo _____ Correo Electronico _____
Persona notificada encaso de emergencia _____
Numero de Telefono _____ Numero de Trabajo _____
Celular _____ Correo Electronico _____
A quien le daremos graciouss por referielo _____

Rason Por La Visita

A vista un quiropractico antes? ☐ Si ☐ No Por que rason _____
Su rason por la vista _____
Porfavor describa su dolor y su locasion _____
Cuando empesaron sus sintomas (fecha)? _____ A tenido condiciones similares en el pasado?
_____
El doloe esta poniendo: ☐ Peor ☐ Mejor ☐ Igual ☐ Va y Viene
Que tan frecuente tiene el dolor? _____
En donde y cuando? _____
Se a tratado con un doctor de estas condicioned? _____
Cuando y donde _____
Actividades o movimientos que estan dificiles para hacer ☐ Sentandose ☐ Caminando ☐ Agachandose
☐ Levantando
Tipo de Dolor: ☐ Fuerte ☐ Pequeno ☐ Doloroso ☐ Camason ☐ Dolor ☐ Matizar ☐ Intumasion ☐ Colico
☐ Rigidez ☐ Inflamasion
El Dolor interfiere con: ☐ Trabajo ☐ Al Dormir ☐ Durante el Dia ☐ Recriacion

Historial De Salud

Escriba medicasion que esta tomando (incluiendo mdicina para dolor) _____
_____
Porfavor escriba cualquier acidente o cirugia que a tenido en los ultimos 10 anos :
Caidas _____ Fecha _____
Accidente en cabeza _____ Fecha _____
Huesos _____ Fecha _____
Deslocasiones _____ Fecha _____
Cirugias _____ Fecha _____
Otros accidentes graves _____
Mujeres : Esta embarasada ☐ Si ☐ No Cuantos meses : _____

Esta dando pecho ? ☐ Si ☐ No

Condiciones Medicales

A tenido o tiene condiciones de la siguiente ?

☐ Hepatitis ☐ Hechar ☐ Anemia ☐ Artritis ☐ Mareos ☐ Cancer ☐ Gota
☐ Sida o HIV ☐ Ulseras/ Colitis ☐ Dolor de Quijada ☐ Dolor en Mano
☐ Dificultar al Respirar ☐ Dolor escueso (Frecuentemente)
☐ Dolor en el Hombro ☐ Dolor en la Piernals ☐ Problems de Espalda
☐ Ataque al Corazon / Embolio ☐ Congestionales del Corazon
☐ Abuse de Drogas o Alcohol ☐ Des mallos, Mareos, Epilepsia
☐ Dolor fuerte de Loido ☐ Sumbido en los Loidos ☐ Diabetis/ Tuberculosis
☐ Glaucoma / Emphysema ☐ Problemas de Riñon
☐ Dolor de Cabeza Fuerte (frecuentemente) ☐ Huesos o Conyuntura Artifisial
☐ Intumido, Donde ?_____
☐ Mantizar, Donde ?_____
☐ Espasmo de musculo, Donde ?_____

Habitos Personales

	Mucho	Mediano	Ligero	Ninguno
Alcohol	☐	☐	☐	☐
Cafe	☐	☐	☐	☐
Tabaco	☐	☐	☐	☐
Drogas	☐	☐	☐	☐
Exercisio	☐	☐	☐	☐
Dormir	☐	☐	☐	☐
Apetito	☐	☐	☐	☐

Authorization

He leido la informacion del questionario y e respondido lo mas que o podido. Entrendo que esta infomacion estaria us do por el quirpractico para deteminar el tratamiento apropiado. Si hay algun cambio en mi status le informare al quiropractico.

Yo autorizo a mi aseguranca para que page al quiropractico y gropo quiropractico los beneficios, distinto pagadero a mi por servicios denretiros. Yo autorizo esta firma a todas asegurancas sumision.

Yo autorizo que el quiropractico de liberar la informacion necesaria para asegurar el pago o benefisios. Yo entiendo que soy responable de pago de page la aseguranza o no.

Firma_____ **Fecha**_____

Descripción Del Accidente

Nombre(Name):_____
Fecha del accidente(D.O.A):_____
Hora(Time):_____ a.m/ p.m
Donde pasó el accidente(Where did the accident happen):_____
Detalles del accidente en sus propias palabras(Accident Details):_____
_____
_____
_____

Que era tu posición en el auto(Position on car)? ☐ Manejador(Driver) ☐ Pasajero(Passenger)
Si fue el pasajero donde estaba(If Passenger)? ☐Adelante(Front) ☐ Trasera Derecha(Right Rear)
☐Izquierda Trasera (Left Rear)
Su vehículo golpeó a otro vehículo(Did your vehicle strike other vehicle)?☐Si ☐No
Su vehículo fue golpeado por otro vehículo(was your car struck by other vehicles)? ☐Si ☐No
En donde fue el impacto(Where was the impact)?☐En Frente(Front) ☐Lado Derecho(Right Side)
☐Lado Izquierdo(Left Side) ☐Trasero(Rear)
Al tiempo del impacto usted estaba(Time of Impact were you)? ☐Mirando Derecho(Looking Straight) ☐Mirando a su izquierda(Looking Left) ☐Mirando a su Derecha(Looking Right)?
Tenía las dos manos el el volante(Were hands on steering wheel)? ☐Si ☐No
Tenía su pie en los frenos(Was your foot on brake)? ☐Si ☐No
Estaba listo para el impacto(Were you brace for impact)?☐Si ☐No
Posición de su cuerpo después del accidente(Position in the car after accident)?_____
_____
Estaba usando su cinturón(Were you wearing seat belts)? ☐Si ☐No
Su cuerpo pegó en algún lado del vehículo a la hora de impacto(Did you strike anything in vehicle at time of impact)? ☐Sí ☐No
Especificar(Specify)? ☐Volante(Steering Wheel) ☐Tablero(Dashboard) ☐Ventana de enfrente(Windshield) ☐Puerta de lado(side Door) ☐Brazo del sillón(Armrest)
☐ Ventana de lado(Side Window) Otro(Other):_____
Especifica la parte del cuerpo(state part of body): ☐Pecho(Chest) ☐Mejilla(Chin) ☐Rodilla(Knee)
☐Hombro(Shoulder) ☐Mano(Hand) ☐Cabeza(Head)
Otro(Other):_____
Después del accidente como se sition(How did you feel after the accident)?_____
_____
Estaba Inconsciente(Were you Unconscious)?☐Si ☐No Aturdido(In daze)? ☐Si ☐No
Fue al hospital(Did you go to hospital)? ☐Si ☐No
Si fue al Hospital, Cuando(If you went to hospital, when)? Hora de accident(time of accident)
☐Si ☐No Al otro dia(Next day) ☐Si ☐No Transportacion privada(Private Trans)? ☐Si ☐No
Los asistentes de la ambulancia te colocaron(Did paramedics place you)?
Collar de cuello(Neck brace)☐Si ☐No Férulas(Splint)☐Si ☐No Abrazadera(Brace)☐ Si☐No
Nombre del Hospital(Name of Hospital):_____
Le tomaron Rayos-X en el hospital(X-Ray taken at hospital)? ☐Si ☐No
Que doctor lo atendió(Attended by doctor)?_____
Que fue el diagnóstico de los Rayos-X(X-Ray results)?_____
_____

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures including examination, diagnostic x-rays and physical therapy techniques, on me (of on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licenses doctors of Chiropractic who now, or in the future, render treatment to me while employed by, working for, or associated with, or serving as back up for the doctor of Chiropractic named below.

I understand that as with any health care procedures, there are certain complications which may arise during Chiropractic adjustment. Those complications include, but are not limited to; fractures, disk injuries or dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then, known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the natural purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the Chiropractic adjustments and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Name(s) of Doctor(s) Treating Patient:

James Baranski, D.C.
Ventura Spine & Sport Chiropractic
4601 Telephone Rd., Suite 110
Ventura, CA 93003
(805) 642-4061

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient Date

_____ _____
Witness to Patient's Signature Date

_____ _____
Translated By Date

Privacy Practices Acknowledgement

I have been given the opportunity to review the Notice of Privacy Practices and understand my rights contained in the notice.

By way of my signature, I provide Advanced Spine & Sport Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Notice of Privacy Practices.

_____

Printed Name of Patient

_____ _____

Patient Signature Date

(EVALUASION/DOLOR DEL PASIENTE)

Patient Pain/Function Evaluation Form

(NOMBRE) **PATIENT NAME:** _____ (FECHA) **DATE:** _____

Please number and mark the **severity of pain** you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

(DOLOR ACTUAL)
- Current pain: ___/10 0 1 2 3 4 5 6 7 8 9 10

(DOLOR PROMEDIO)
- Average pain: ___/10 0 1 2 3 4 5 6 7 8 9 10

PAIN LEVEL DURING:

(ACTIVIDADES DE LA VIDA DIARIA)
- Activities of Daily Living: ___/10 0 1 2 3 4 5 6 7 8 9 10

(TRABAJO)
- Work: ___/10 0 1 2 3 4 5 6 7 8 9 10

(DEPORTES)
- Sports/Recreation: ___/10 0 1 2 3 4 5 6 7 8 9 10

Please describe the **type of pain** or sensation you are currently experiencing. (Check all that apply)

- ☐ Aching/DOLOR
- ☐ Burning/ARDIENTE
- ☐ Cramps/CALAMBRES
- ☐ Dull/DOLOR Sordo (Leve)
- ☐ Numbness/ENTUME
- ☐ Sharp/AGUDO
- ☐ Shooting/DOLOR INSOPORTABLE
- ☐ Stabbing/Puñalada
- ☐ Stiffness/RIGIDEZ
- ☐ Swelling/INCHADO
- ☐ Throbbing/PUNZANTE
- ☐ Tingling/HORMIGAS

OTRO? DESCRIBA? Other, describe it: _____

Activities or movements that are painful to perform: Actividades oh MOVIMIENTOS QUE SON DIFFICIL?

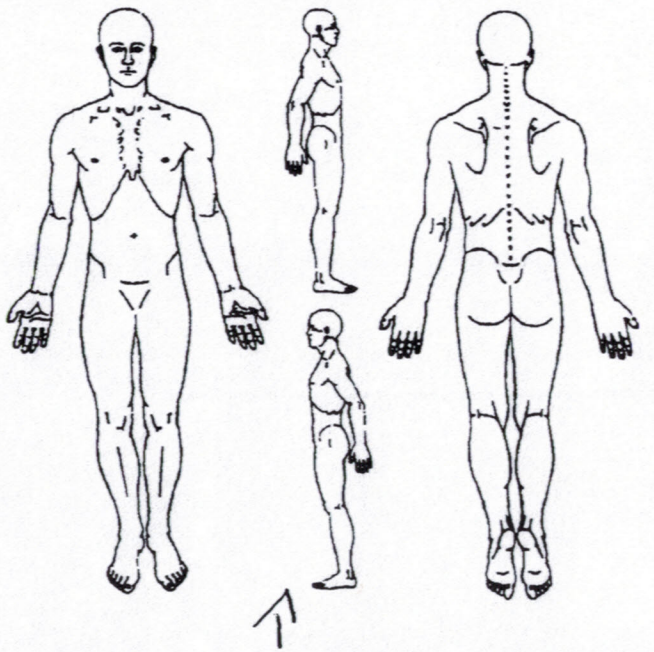
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ None ☐ Other _____

Sentado PARADO CAMINAR Agachado ACOSTADO NADA OTRO?

When and what makes it better? QUE LO HACE SENTIR MEJOR?

When and what makes it worse? QUE LO HACE SENTIR PEOR?

Please mark on the diagram the location of the pain.



POR FAVOR MARQUE EN DONDE EXSATAMENTE EL DOLOR.

NOTICE OF DOCTOR'S LIEN
(Under California State Insurance Code #10133)
ADVANCED SPINE AND SPORT CHIROPRACTIC
4601 TELEPHONE RD. SUITE 110
VENTURA, CA 93003
Phone: (805) 642-4061 Fax: (805) 642-7295

Patient: _____ **Date of Accident:**_____

I do hereby authorize James Baranski, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to James Baranski, D.C. such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are die his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate James Baranski, D.C. And I hereby further give a lien on my case to James Baranski, D.C. against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to James Baranski, D.C. for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify James Baranski, D.C. of any change or addition of attorney(s) used by in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____
Dated **Patient's Signature**

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____
Dated **Attorney's Signature**

**This office holds an assignment/lien on this case for services rendered. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to James Baranski, D.C. for payment.

NOTICE OF DOCTOR'S LIEN
(Under California State Insurance Code #10133)
ADVANCED SPINE AND SPORT CHIROPRACTIC
4601 TELEPHONE RD. SUITE 110
VENTURA, CA 93003
Phone: (805) 642-4061 Fax: (805) 642-7295

Patient: _____ **Date of Accident:**_____

I do hereby authorize James Baranski, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to James Baranski, D.C. such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are die his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate James Baranski, D.C. And I hereby further give a lien on my case to James Baranski, D.C. against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to James Baranski, D.C. for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify James Baranski, D.C. of any change or addition of attorney(s) used by in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____
Dated **Patient's Signature**

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____
Dated **Attorney's Signature**

**This office holds an assignment/lien on this case for services rendered. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to James Baranski, D.C. for payment.

ADVANCED
Spine & Sport
MEDICAL REHABILITATION CENTER

James Baranski, D.C.

THIRD PARTY MEDICAL LIEN

Patient's Name:_____

Social Security Number:_____

Date of Injury:_____

I hereby authorize direct_____Insurance Company, to pay Advanced Spine & Sport Medical Rehabilitation Center Inc. such sums as may be due and owing him for chiropractic/medical services rendered me by reason of the accident and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further request that payment be made DIRECTLY to say doctor which would be paid by myself, as the result of treatment charges incurred for injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me and that this agreement tis made solely for said doctor's protection and in consideration of this awaiting payment. I further understand that such payment is not contingent on my settlement, judgement or verdict by which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning this to the doctor's office. I have been advice if you not wish to cooperate in protecting the doctor's interest; the doctor will not await payment but may declare the entire balance due and payable to me.

Patient Signature:_____Date:_____

The undersigned insurance company does hereby agree to observe all the terms of the above and agrees to withhold sums from any settlement, judgement or verdict, as may necessary to adequately protect and fully compensate said Doctor above-name and make payment directly to said doctor.

Please date, sign and return the original to the Doctor's office. Also keep one copy for your records.

Date: _____

_____

Signature of Insurance Company Representative

_____

Insurance Company Name

4601 Telephone Rd Suite #110, Ventura, CA 93003 * P: (805) 642-4061 * F: (805) 642-7295

ADVANCED
Spine & Sport
MEDICAL REHABILITATION CENTER

James Baranski, D.C.

FINANCIAL AGREEMENT
PERSONAL INJURY

We would like to take a moment to welcome you to our office and to assure you that you will receive the best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

PARTY RESPONSIBILITY:
If you were involved in an auto accident in your own vehicle, we will bill the medical portion or Personal Injury Protection portion of your insurance policy to cover the treatment charges incurred in our office.

MED PAY:
If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.

PIP:
If you were a passenger in another vehicle , and you own a car which as PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.

3RD PARTY: If another vehicle has caused the accident, we will first bill your automobile MedPay or PIP policy coverage PRIOR to submitting a claim to the insurance carrier of the party at fault.

It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be funded to you.

ATTORNEY LIENS:
If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

RESPONSIBILITY FOR PAYMENT:
As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial agreement, if, at any time, you have further questions about your care, please do not hesitate to ask

I have read and agree to the above

_____ _____

Patients Signature **Date**

4601 Telephone Rd Suite #110, Ventura, CA 93003 * P: (805) 642-4061 * F: (805) 642-7295

Descripción Del Accidente

Lo admitieron al hospital(Were you admitted to hospital)? ☐Si ☐No
Cuanto tiempo se quedó en el hospital(How long did you stay)?_____
Que tratamiento le dieron(What treatment was rendered)?_____
_____
Qué recomendaciones le dieron(what did they recommend)? ☐Ver a su propio doctor(See own doctor) ☐Ver a un Ortopédico(See orthopedic doctor) ☐Terapia física(Physical Therapy)
A visto algun otro doctor resultado del accidente(Seen any other doctor since accident)? ☐Si No
Nombre del Doctor(Name of doctor)?_____
Su dolor es constante(Is pain constant)? ☐Si ☐No
El dolor se le va y viene(comes & goes)? ☐Si ☐No Fuerte(Sharp)? ☐Si ☐No
Mediano(Dull)? ☐Si ☐No Otro(other):_____

Cheque algunas que ha notado desde el accidente(Check the ones that apply):

☐Dolor de cabeza (Headache)
☐Dolor de cuello (Neck Pain)
☐Rigidez en el cuello (Neck Stiff)
☐Problemas para dormir (Sleeping problem)
☐Dolor de espalda (Back pain)
☐Dolor de estomago (Stomach Upset)
☐Perdida de apetito (Loss of appetite)
☐Luz le molesta sus ojos (Light bother eyes)
☐La cabeza se siente pesada (Head feels heavy)
☐Eritable (Irritable)
☐Dolor de pecho (Chest Pain)
☐Mareos (Dizziness)
☐Dedos intuidos (Numbness in fingers)
☐Nerviosismo (Nervousness)
☐Hoidos ruidosos (Ears Ringing)
☐Desmayo (Fainting)
☐Dedos de los pies entumidos (Numbness in toes)
☐Agitada al respirar (Shortness of breath)
☐Depresion (Depression)
☐Tension (Tension)
☐Perdida de memoria (Lost of memory)
☐Perdida de balance (Loss of balance)
☐Sensación de piquetes en las manos (Numbness on hand)
☐Pies frios (Cold Feet)
☐Manos frias (Cold hands)
☐Siente piquetes en la piernas (Numbness on legs)
☐Fatigue (Fatigue)
☐Estrinido (Constipation)
☐Fievre (Fever)
☐Pies Frios (Cold feet)
☐Saldo Perdido (Loss of balance)
☐Diarrea (Diarrhea)

El dolor le es más cuando se levanta de silla(Pain increase when rising of a chair)? ☐Si ☐No
Se le empeora al estar parado/a(Is it worse standing)? ☐Si ☐No
Cuando tose(Coughing)? ☐Si ☐No Al estornudar(Sneezing)? ☐Si ☐No Al aser del bano(taking a bowels)? ☐Si ☐No Tiene entumecimiento y hormigueo en los brazos(N/T on arms)? ☐Si ☐No
En las manos(N/T hands)? ☐Si ☐No En los dedos(N/T finger)? ☐Sí ☐No
Las piernas(N&T legs)? ☐Si ☐No Los pies(N&T feet)? ☐Si ☐No Los dedos de los pies(N&T in toes)? ☐Sí ☐No Cuál es su posición más cómoda/o(Most comfortable position)?
sentado/a(sitting)? ☐Si ☐No Acostado en el lado derecho(Laying on your right)? ☐Si ☐No
Acostado en el lado izquierdo(Laying on your left)? ☐Sí ☐No
Acostado en su espalda(Laying on your back)? ☐Si ☐No Acostado en su estómago(On your stomach)? ☐Si ☐No Parado/a(Standing)? ☐Si ☐No Otro(other):_____
Es difícil de moverse en la cama(difficult to move in bed)? ☐Si ☐No
A perdido tiempo en su trabajo por el accidente(Missed days of work)? ☐Si ☐No
Si a perdido tiempo de trabajo cuáles fechas y tiempo de desestabiliza fechas(If yes, give dates)?
_____, Asta(To) _____
Desestabilizar parcial fechas(total disabled days)?_____