

### **BRAZOS VALLEY REHABILITATION CENTER**

1318 Memorial Drive

Bryan, Texas 77802

Phone: 979-776-2872 fax: 979-776-1456

PEDIATRIC CASE HISTORY FORM

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Areas of concern: \**check all that apply*

**🞎** Speech Articulation (pronouncing sounds/words) **🞎** Feeding/Swallowing **🞎** Fine Motor (handle small items with fingers)

**🞎** Receptive Language (following directions, understanding language) **🞎** Play Skills **🞎** Hand-writing

**🞎** Expressive Language (forming sentences, expressing self) **🞎** Reading **🞎** Sensory

**🞎** Social Skills **🞎** Attention **🞎** Gross Motor (sitting, walking, throwing, jumping)

**🞎** Stuttering **🞎** Behavior **🞎** Difficulty turning head

**🞎** Voice **🞎** Unable to sit still  **🞎** Frequent falls/clumsy

Describe your concerns and goals for therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Pregnancy/Birth History:**

Pregnancy: **🞎** Normal **🞎** Abnormal/Complications (explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Delivery: **🞎** Vaginal **🞎** Cesarean Birth weight: \_\_\_\_lbs. \_\_\_\_ oz. Premature: **🞎** No **🞎** Yes # of weeks born at: \_\_\_\_\_\_\_\_

Postnatal History: **🞎** Jaundice **🞎** Required Oxygen **🞎** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Abnormalities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Feeding/Swallowing Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Is your child taking medicine? **🞎** Yes **🞎** No

List medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child allergic to any of the following? **🞎** latex **🞎** food **🞎** medication **🞎** otherIf yes*, list*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **🞎**no

**\***Has your child had any of the following?

**🞎** Surgery/hospitalization **🞎** Heart problems **🞎** Vision problems **🞎** Seasonal allergies **🞎** Diabetes **🞎** Movement limitations

**🞎** Serious accident/injury **🞎** Digestive problems **🞎** Hearing problems **🞎** Ear infections **🞎** G-Tube **🞎** Frequent falls

**🞎** Chronic illness **🞎** Breathing problems **🞎** Swallowing problems **🞎** Tubes in Ears **🞎** Seizures **🞎** Joint problems

**🞎** Genetic disorder/Syndrome **🞎** Neurological problems **🞎** Sleeping difficulties **🞎** Acid Reflux/GERD **🞎** Body pain **🞎** Other

*\*\*Please explain any checked items here:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Vision/Hearing:**

Has the child had a hearing test? **🞎** Yes **🞎** No Results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where? **🞎** school  **🞎** Physician **🞎** Audiologist **🞎** ENT **🞎** hospital

Recommendations? **🞎** audiological evaluation **🞎** hearing aid **🞎** cochlear implant **🞎** other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **🞎** none

Has the child had a vision test? **🞎** Yes **🞎** No Results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child wear glasses? **🞎** Yes **🞎** No

**Developmental Milestones:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Developmental Skill** | **Age Achieved** | **Developmental Skill** | **Age Achieved** |
| Lift head while on tummy |  | Stand alone |  |
| Roll |  | Walk |  |
| Sit alone |  | Babble |  |
| Hold toys while sitting |  | First word |  |
| Crawl on tummy/crawl on all fours/scoot on bottom |  | Put 2 words together |  |
| Walk sideways using furniture |  | Taken off bottle/breast |  |
| Potty trained |  |  |  |

**Speech & Language:**

Language(s) besides English spoken in the home? **🞎** Yes **🞎** No If yes, what language(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language child understands best?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language child speaks most often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child communicate the majority of the time? **🞎** pull you to object **🞎** gesture/point **🞎** makesounds **🞎** words **🞎** phrases

**🞎** sentences **🞎** sign language **🞎** communication book **🞎** communication device **🞎** other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does your child understand? *Check all that apply.* **🞎** simple directions **🞎** 2-step directions **🞎** wh- questions **🞎** yes/no questions **🞎** conversation

How much can the parents understand of their speech? **🞎** all **🞎** most  **🞎**some **🞎** none

How much can others understand of their speech? **🞎** all **🞎** most  **🞎**some **🞎** none

List sounds that your child has trouble pronouncing:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Feeding History:**

Does the child have trouble swallowing? **🞎**Yes **🞎** No Does child have difficulty chewing? **🞎** Yes **🞎** No

Has the child had a swallow study? **🞎**Yes **🞎** No Avoids certain food textures/temperatures? **🞎** Yes **🞎** No

 If yes, list results/recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sensitive in/around mouth/face/head **🞎** Yes **🞎** No

Is the child a “picky” eater? **🞎** Yes **🞎** No Does the child drool? **🞎** Yes **🞎** No

Is the child a messy eater? **🞎** Yes **🞎** No Was weaning a problem? **🞎** Yes **🞎** No

**Family History:**

Who is your child’s legal guardian? **🞎** parents **🞎** mother  **🞎** father **🞎**other, *list name and relationship***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Marital status of parents: **🞎** single **🞎** married **🞎** separated  **🞎** divorced **🞎** widowed Is your child adopted? **🞎** Yes **🞎** No

List everyone in the child’s primary household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#of adults in the home: \_\_\_\_\_\_\_\_ # of children in the home: \_\_\_\_\_\_\_\_\_\_\_\_ Ages of children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does your child spend most of his time at home doing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have any relatives had developmental delays, physical problems or learning disabilities/disorders? If yes, *please list*. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are there stairs in the home? **🞎** Yes **🞎** No If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_ Is there a handrail? **🞎** Yes **🞎** No

**School History:**

Does your child attend a day care or school? **🞎** Yes **🞎** No If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is their current grade level? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does your child have an aide? **🞎** Yes **🞎** No

Has your child repeated a grade? **🞎** Yes **🞎** No If yes, what grade? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are they in a special program or class? **🞎** Yes **🞎** No If yes, *list* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child receive therapy at school? **🞎** Yes **🞎** No If yes what? **🞎**PT **🞎**OT **🞎**Speech **🞎**Vision

What’s your child’s biggest difficulty at school? **🞎**particular subject(s), *list*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **🞎**PE **🞎**getting along with peers **🞎**conduct/behavior  **🞎**other, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

On average, what are your child’s grades? **🞎**A’s (90-100) **🞎**B’s (80-89) **🞎**C’s (70-79) **🞎**F’s (below 70)

**Other:**

Has your child seen any of the following professionals?

**🞎** Geneticist **🞎** Neurologist **🞎** Developmental Pediatrician **🞎** Physical Medicine Rehabilitation Physician

**🞎** ENT **🞎** Orthotist **🞎** Behavioral Therapist **🞎**Speech-Language Pathologist

**🞎** Other **🞎** Psychologist **🞎** Physical therapist **🞎** Occupational therapist

If you checked yes to any of the following, please list the name of the professional, when they were seen, and if applicable the resulting diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Below is a list of words which describe a child’s personality or behavior. Please check those which you feel tend to describe your child:

 **🞎** Shy **🞎** Hard to discipline **🞎** Very Active **🞎** Toe walker

 **🞎** Happy **🞎** Has temper tantrums, **🞎** Independent **🞎** Frequent faller

 **🞎** Moody how often? \_\_\_\_\_\_\_ **🞎** Dependent **🞎** Slow moving

 **🞎** Friendly **🞎** Fights with peers/siblings **🞎** Leader

 **🞎** Clumsy/awkward **🞎** Even tempered **🞎** Follower

 **🞎** Nervous/anxious **🞎** Has trouble sleeping **🞎** Prefers to be alone

 **🞎** Perfectionist **🞎** Sucks thumb/pacifier **🞎** Quiet

 **🞎** Easily frustrated **🞎** Overly sensitive to touch/sound/smells **🞎** Negative behaviors \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Patient/Guardian Signature Date

Is there any other information we need to know?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.