



Comprehensive Screening (without Breast) Questionnaire

Today's Date: _____

First Name	Last Name	Suffix	Preferred First Name	
Date of Birth	Home Phone #	Cell Phone #		
Street Address	Apt #	City	State	Zip Code
Email Address				
Referring Physician or Provider				

General Exam Disclosures

- Thermography is a no-contact, non-invasive procedure. You will be imaged with a state-of-the-art infrared camera in a comfortable, private, temperature-controlled room by a highly-trained technician.
- The value of thermography as a screening tool is its ability to measure skin temperature changes. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. Your thermal imaging report will provide information about your current condition only and **does not diagnose disease**.
- I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that **the report will not tell me whether I have any illness, disease or condition**, but will be an analysis of the images with respect only to the thermographic findings discussed in the report.

By signing below, I certify that I have read and understand the statement above and consent to the examination. I am not an undercover agent or acting on behalf of law enforcement or the media.

Signature of Client*

Date

**Typing your complete name in the appropriate field above constitutes an electronic signature.*

Head & Neck

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you suffer with headaches?
If yes: <input type="checkbox"/> Once a month or less <input type="checkbox"/> More than once a month | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have known allergies?
If yes: <input type="checkbox"/> Food <input type="checkbox"/> Environmental | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have TMJ or does your jaw click? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you currently have a cold? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you being treated for a thyroid disorder?
If yes, please specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have neck pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have upper back pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have a known history of carotid artery disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have a family history of stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you currently suffer with sinus problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have a history of dental problems?
If yes: <input type="checkbox"/> Root canal(s) <input type="checkbox"/> Gum disease <input type="checkbox"/> Implants
<input type="checkbox"/> Non-replaced extractions <input type="checkbox"/> Dentures | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you had a dental cleaning in the past 7 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you been diagnosed with elevated cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have any special concerns and/or would you like to provide any details related to the information above?

Chest, Heart & Lungs

	Yes	No
1. Have you been diagnosed with:		
Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
Upper spine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you suffer with upper back pain?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you suffer with chest pain?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had surgery to your:		
Heart?	<input type="checkbox"/>	<input type="checkbox"/>
Lungs?	<input type="checkbox"/>	<input type="checkbox"/>
Mid to upper back?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have asthma or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you currently smoke?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you smoked in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any special concerns and/or would you like to provide any details related to the information above?		
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<hr/>		

Abdomen & Lower Back

	Yes	No		Yes	No
1. Do you suffer with acid reflux or other digestive problems?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery or disease of the:		
			Stomach?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you suffer pain in the:			Spleen (Upper Left)?	<input type="checkbox"/>	<input type="checkbox"/>
Stomach?	<input type="checkbox"/>	<input type="checkbox"/>	Liver (Upper Right)?	<input type="checkbox"/>	<input type="checkbox"/>
Below R Breast?	<input type="checkbox"/>	<input type="checkbox"/>	Kidneys?	<input type="checkbox"/>	<input type="checkbox"/>
Below L Breast?	<input type="checkbox"/>	<input type="checkbox"/>	Intestines?	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen?	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen?	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back?	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back?	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic Region?	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic Region?	<input type="checkbox"/>	<input type="checkbox"/>
Have you consumed alcohol in the past 24 hours?				<input type="checkbox"/>	<input type="checkbox"/>

Legs & Feet

<i>Check box only if "Yes"</i>	Left	Right		Left	Right
1. Do you suffer with pain in the:			2. Have you had surgery to:		
Leg?	<input type="checkbox"/>	<input type="checkbox"/>	Leg?	<input type="checkbox"/>	<input type="checkbox"/>
Sciatica?	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica?	<input type="checkbox"/>	<input type="checkbox"/>
Buttocks/Hip?	<input type="checkbox"/>	<input type="checkbox"/>	Buttocks/Hip?	<input type="checkbox"/>	<input type="checkbox"/>
Knees?	<input type="checkbox"/>	<input type="checkbox"/>	Knees?	<input type="checkbox"/>	<input type="checkbox"/>
Ankles?	<input type="checkbox"/>	<input type="checkbox"/>	Ankles?	<input type="checkbox"/>	<input type="checkbox"/>
Feet?	<input type="checkbox"/>	<input type="checkbox"/>	Feet?	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any special concerns and/or would you like to provide any details related to the information above?

Arms & Hands

<i>Check box only if "Yes"</i>	Left	Right		Left	Right
1. Do you suffer with pain in the:			2. Have you had surgery to:		
Shoulder?	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder?	<input type="checkbox"/>	<input type="checkbox"/>
Elbow?	<input type="checkbox"/>	<input type="checkbox"/>	Elbow?	<input type="checkbox"/>	<input type="checkbox"/>
Arm?	<input type="checkbox"/>	<input type="checkbox"/>	Arm?	<input type="checkbox"/>	<input type="checkbox"/>
Hands?	<input type="checkbox"/>	<input type="checkbox"/>	Hands?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been diagnosed with diabetes?				Yes	No
				<input type="checkbox"/>	<input type="checkbox"/>

Do you have any special concerns and/or would you like to provide any details related to the information above?

Client Acknowledgement

To the best of my knowledge, the information provided above is accurate and complete.

Signature of Client*

Date

*Typing your complete name in the appropriate field above constitutes an electronic signature.