Health 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 signatur*e.

Client Acknowledgement

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

Signature of Client* **Date**

Your responses below will be disclosed only to the extent necessary and/or in accordance with your written authorization.

Head & Neck

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

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

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Chest, Heart & Lungs

	Yes	No
1. Have you been diagnosed with:		
Heart disease?	☐	☐
Lung disease?	☐	☐
Upper spine disorders?	☐	☐
2. Do you suffer with upper back pain?	☐	☐
3. Do you suffer with chest pain?	☐	☐
4. Have you ever had surgery to your:		
Heart?	☐	☐
Lungs?	☐	☐
Mid to upper back?	☐	☐
5. Do you have asthma or shortness of breath?	☐	☐
6. Do you currently smoke?	☐	☐
7. Have you smoked in the past 5 years?	☐	☐

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

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Abdomen & Lower Back

	Yes	No
1. Do you suffer with acid reflux or other digestive problems?	☐	☐
2. Do you suffer pain in the:		
Stomach?	☐	☐
Below R Breast?	☐	☐
Below L Breast?	☐	☐
Abdomen?	☐	☐
Lower Back?	☐	☐
Pelvic Region?	☐	☐

Have you had surgery or disease of the:	Yes	No
Stomach?	☐	☐
Spleen (Upper Left)?	☐	☐
Liver (Upper Right)?	☐	☐
Kidneys?	☐	☐
Intestines?	☐	☐
Abdomen?	☐	☐
Lower Back?	☐	☐
Pelvic Region?	☐	☐

	Yes	No
Have you consumed alcohol in the past 24 hours?	☐	☐