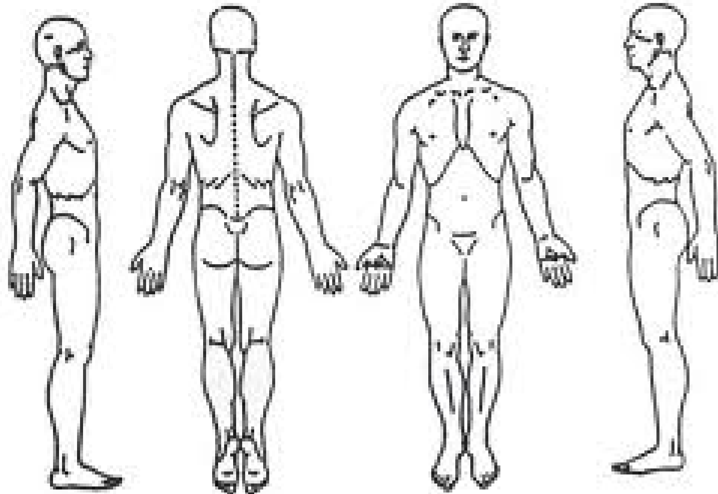
Full Body Study Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting thermologist and any other practitioner that you specify.

Name:___________________________________ Birthdate:___________________
Address:____
Phone:___________________________________

Please Show areas of:
Main Pain *
Secondary Pain #
Numbness /////
Pins and Needles ^^^^^
Skin lesions / Scaring



Do you know what triggered the pain?

Does anything relieve the pain?

Does anything aggravate the pain?

Has the pain changed since it began?

Have you had any treatment?

History of Injuries/Fractures/Surgery (type & date):

____

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis.

I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature:____ Date:__________________