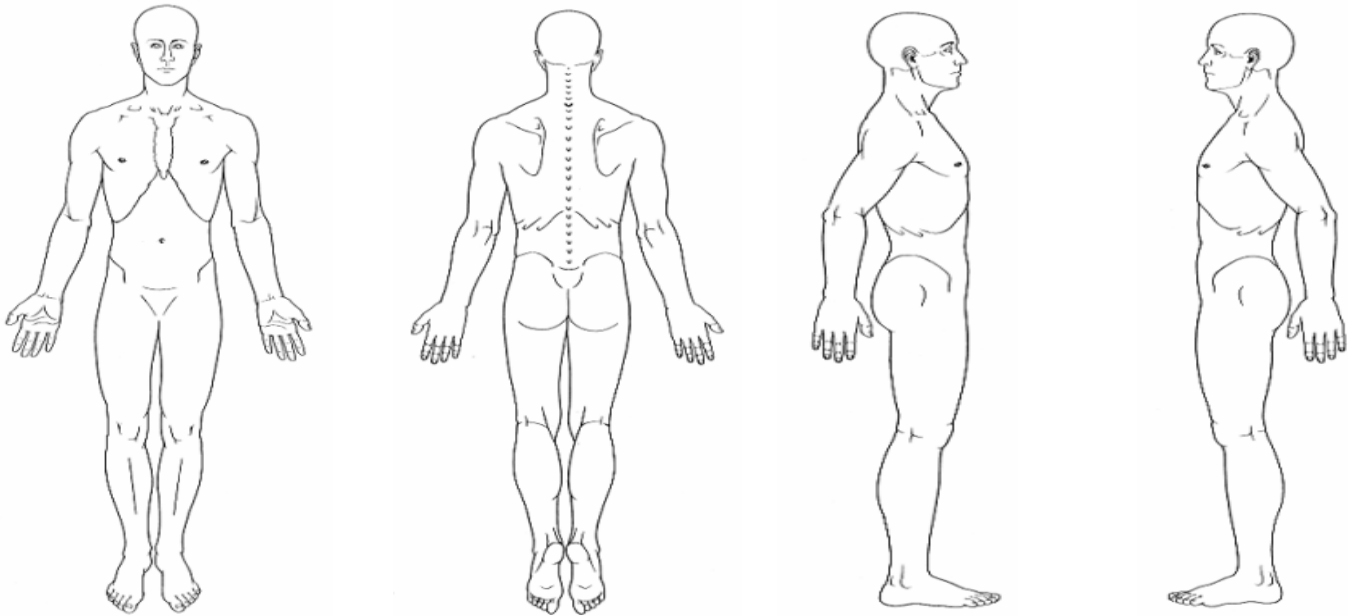


Full Body and Pain History

Name: _____ Email: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Date of Birth: _____ Age: _____ Sex: _____
Referred by: _____

Mark the location of symptoms with an "X" and label it as sharp, dull, burning, aching, etc.



Please Note Level of Pain

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10
Mild: Annoyance **Moderate: Some Limitations** **Severe: Pain Killers Needed**

Describe your symptoms: _____

How and when did this start? _____

Were you examined for this complaint? _____

Date and Results: _____

What increases your symptoms? _____

What decreases your symptoms? _____

What medications are you taking? _____

List any treatments you have had: _____

List any other medical conditions: _____

List any past surgeries: _____

List and describe the location of any rash or marking on your body: _____

Practitioner in charge of your health: Name: _____

Address: _____

Phone: _____ Zip _____

May we send him or her your report? Y N

Release for Testing Procedure

Thermal Imaging provides physiological and functional diagnostic information and does not replace any other diagnostic procedure.

I have read the above information and understand that I am not receiving a diagnosis based on my thermal scan. I authorize this clinic's personnel to perform this and all subsequent thermal imaging examinations.

I have complied with the pre-examination instructions for proper thermal imaging

Print Name _____ Signature _____ Date _____

Please do not write in this section

Initial Exam Re-Exam Tech _____

Patient T = _____ F Laboratory Temperature _____ C

Additional info: _____

