Full Body 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: Birth date:

Address: City: Zip:

Phone: Your Doctor:

Please use the symbols below to indicate areas of :

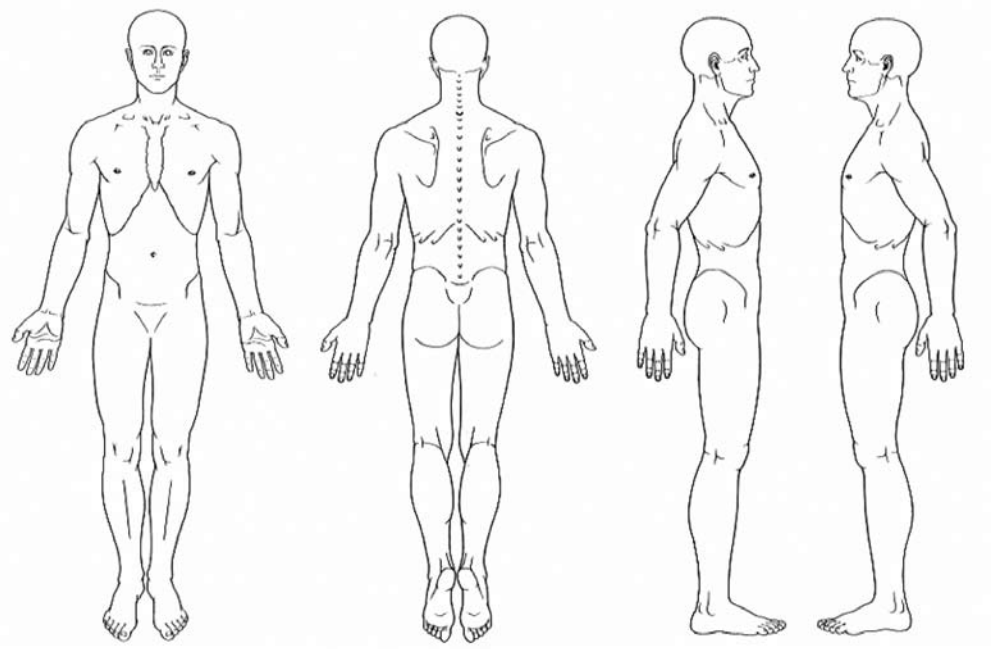
Main Pain ✻

Secondary Pain ❍

Numbness ////////

Pins and needles ::::::::

Skin lesions / scarring



Do you know what triggered the pain ?

_____

Does anything relieve it ?

_____

Does anything aggravate it ?

_____

Has it changed since it began ?

_____

Have you had any treatment ?

_____

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_____