Patient Intake Form

Name____

Date of Birth____

Age____

Street Address____

Town____

State and Zip____

Email____

Phone: (H)____________________ (C)____________________

For Office Use Only

Patient ID#:
Report#:
Breast Report Results:
L: __________ R: __________
Send to Practitioner: Yes No
Date sent to Client:
USPS or Email
Fee Amt:________
Cash Check CC

Reason for Today's Visit: ____

____

Current Symptoms: ____

____

Current Treatments/Self Care Routines (ie. Massage, Chiropractic, Diet: ______________________

____

Previous Surgeries/Dates: ____

____

Previous Illnesses: ____

____

Patient Intake Form

Current Medications: ____________________

____

Current Supplements: ____________________

____

Would you like your health care practitioner to receive a copy of your report?

Yes ☐ No ☐

Name of health care practitioner and title (Dr, DO, PA, NP): ____________________

____

Street Address: ____________________

City/ State/ Zip: ____________________

An additional $3.00 will be applied to forms sent to more than 1 additional health care practitioner as indicated on the request form (page 9).

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.

Signed: ____________________ Date: ____________

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