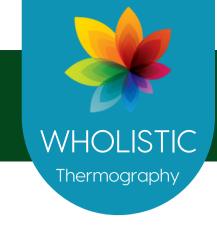


Patient Intake Form

Name		
Date of Birth	For Office Use Only Patient ID#:	
Age	Report#: Breast Report Results:	
Street Address	L: R:	
Town	Send to Practitioner: Yes No Date sent to Client: USPS or Email	
State and Zip	Fee Amt:	
Email	Cash Check CC	
Phone: (H)(C)		
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:	
Yes	care practitioner to receive a copy of your report?
Name of health care practiti	ioner and title (Dr, DO, PA, NP):
Street Address:	
City/ State/ Zip:	
An additional \$3.00 will be ap indicated on the request form	oplied to forms sent to more than 1 additional health care practitioner as a (page 9).
in evaluation, diagnosis, and treatme or self-diagnosis. I understand that th analysis of the Images with respect o	the Report generated from my images is intended for use by trained health care providers to assist nt. I further understand that the Report is not intended to be used by individuals for self-evaluation ne Report will not tell me whether I have any illness, disease, or other condition, but will be an nly to the thermographic findings of the areas discussed in the Report. By signing below, I certify statements above and consent to the examination.
Signed:	Date:

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