

Name: _____ Date of Birth: _____
FIRST MIDDLE INITIAL LAST

Address: _____
STREET ADDRESS CITY STATE ZIP CODE

Home Phone: _____ Cell Phone: _____ Call Preference: Home / Cell

Email: _____

Referred by: _____ Doctor _____

☐ Male ☐ Female

If female: # pregnancies? _____ # births? _____

Directions: You do not need to duplicate information filled out on other forms. Answer questions that pertain to you

List below your four main health complaints in order of importance:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Current Medications, supplements and treatments (dose/frequency) _____

Health History - Please note "c" for current or "p" for past. This information helps us identify safe protocols for your particular needs.

Circulatory

- ☐ Heart Condition
- ☐ Phlebitis/Varicose Veins
- ☐ Blood Clots
- ☐ High/Low Blood Pressure
- ☐ Lymphedema
- ☐ Thrombosis/Embolism
- ☐ Heart attack
- ☐ Stroke
- ☐ Pacemaker

Digestive

- ☐ Irritable Bowel Syndrome
- ☐ Bladder/Kidney Ailment
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Ulcers

Musculoskeletal

- ☐ Bone or joint disease
- ☐ Tendonitis/Bursitis
- ☐ Arthritis/Gout
- ☐ Jaw Pain (TMJ)
- ☐ Lupus
- ☐ Spinal Problems
- ☐ Migraines/Headaches
- ☐ Osteoporosis

Nervous System

- ☐ Shingles
- ☐ Numbness/Tingling
- ☐ Pinched Nerve
- ☐ Chronic Pain
- ☐ Paralysis
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease

Reproductive

- ☐ Pregnant? week: _____
- ☐ Ovarian/Breast cysts
- ☐ Menstrual Problems
- ☐ Endometriosis
- ☐ Organ Prolapse
- ☐ Hypertonic pelvic
- ☐ Hysterectomy (full or partial?)
- ☐ Vasectomy
- ☐ Breast Implants (date _____)
Type: _____
- ☐ Menstruating?
- ☐ Last Period ended: _____
- ☐ Hormone Replacement therapy?
- ☐ bioHRT ☐ Other
- ☐ Birth Control
- ☐ Years (or age taken) _____

Respiratory

- ☐ Breathing Difficulty/Asthma
- ☐ Emphysema
- ☐ Allergies, specify: _____
- ☐ Sinus Problems

Skin

- ☐ Allergies, specify: _____
- ☐ Rashes
- ☐ Cosmetic Surgery
- ☐ Athlete's Foot
- ☐ Herpes/Cold Sores
- ☐ Scars
- ☐ Tattoos
- ☐ Infection

Other:

- ☐ Cancer/Tumors
Type: _____
- ☐ Diabetes
- ☐ Fibromyalgia, Lupus
- ☐ Lyme
- ☐ Immune _____
- ☐ Hypo/Hyperthyroid
- ☐ Drug/Alcohol
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Fainting
- ☐ Hearing Aids
- ☐ Contact Lenses
- ☐ Dentures
- ☐ Dental implants
- ☐ Root Canals
- ☐ Surgical implants
- ☐ Organ transplant
- ☐ Organ excision

- ☐ Bloodthinner Rx
- ☐ Cholesterol Rx
- ☐ Anti-Depressant Rx
- ☐ Antacid Use
- ☐ Sleep Rx
- ☐ Other: _____

Surgeries/Dates:

Scars or tattoos (locations)

Family History:

(check applicable squares)

	Cancer	Diabetes	Heart Disease
Father _____			
Grandfather (P) _____			
Grandmother (P) _____			
Mother _____			
Grandmother (M) _____			
Grandfather (M) _____			
Sibling _____			

HEALTH HISTORY (con't)

Pertinent dates or explanations for conditions marked on previous page: _____

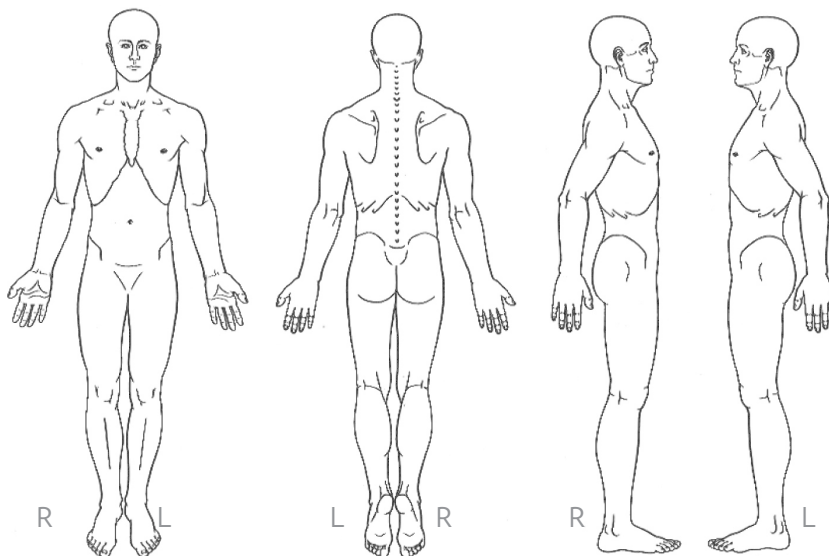
History/Date: Surgeries, Injuries, Chronic conditions: _____

Clinical correlation to previous scan, mammogram or other tests: _____

Descriptions of Pain or Injury:

On the diagrams below, please indicate areas of:

- | | |
|-------------------------|---------------------------------------|
| X Worst Pain | ::: Pins & needles |
| O Secondary Pain | > Skin lesions / scarring |
| /// Numbness | + Injury, fractures or surgery |



Is your condition the result of a recent accident or injury?

- ☐ Yes ☐ No If yes, which if the following apply?
- | | | |
|--|--|--------------------------------|
| ☐ auto accident | ☐ personal injury | ☐ other |
| ☐ work injury | ☐ sports injury | |

Date & description of injury: _____

Is your condition the result of a past accident or injury?

- ☐ Yes ☐ No If yes, please describe

Do you know what triggered the pain? ☐ Yes ☐ No

If yes, please describe _____

Does anything relieve it? ☐ Yes ☐ No If yes, please describe

Does anything aggravate it? ☐ Yes ☐ No If yes, please describe

PATIENT DISCLOSURE FOR THERMOGRAPHIC AND/OR MSA TESTING:

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 or electrodermal findings discussed in the Report(s). I understand that Medicare does not cover this test. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature _____ Date _____