Full Body and Pain History

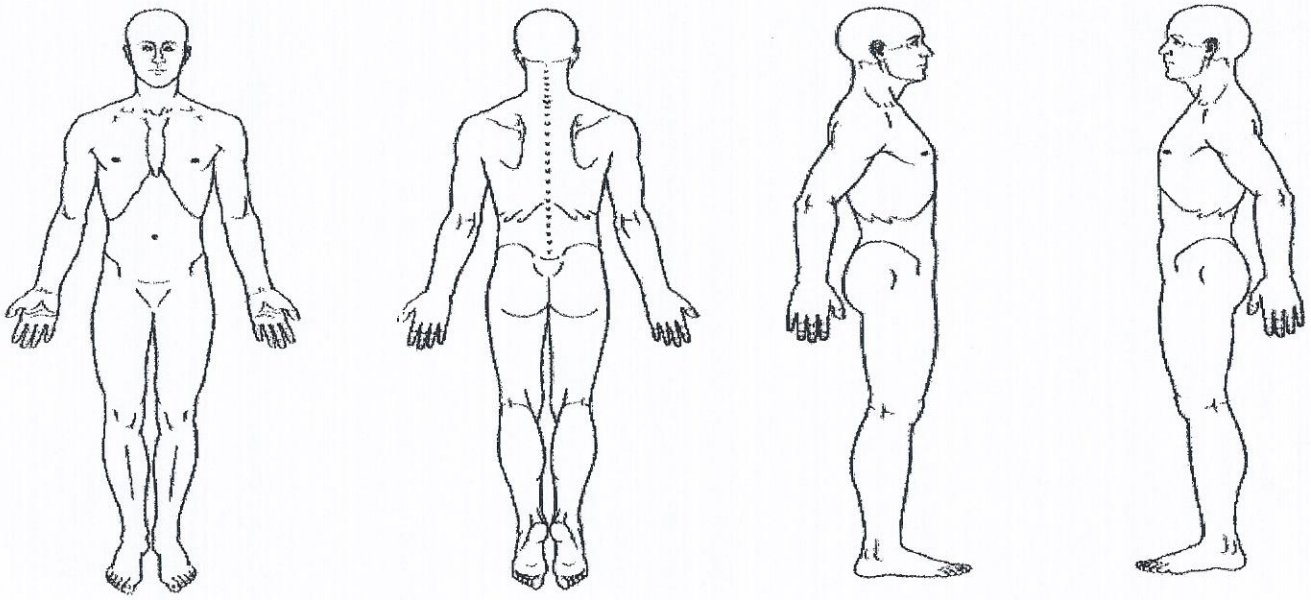
Name:_____ Email: _____ Date: _____

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? _____

_____

List any treatments you have had: _____

_____

List any past surgeries especially related to your concern: _____

_____

List any other medical conditions: _____

What medications are you taking? _____

_____

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

_____

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