Confidential Questionnaire

Men's Full Body

Name_________________________________ Birth Date_________ Today's Date____________

Address_________________________________ City______________ State________ Zip_________

Phone Number (home)_________________(cellular)________________(work)__________________

E-Mail Address______________________________Referring Physician___________________________

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermographer and any other practitioner that you specify.

	Yes	No
Head & Neck		
1. Do you suffer with headaches?	___	___
If yes, once a month or less ___ more than once a month ___		
2. Do you have known allergies? Food ____ Environmental___	___	___
3. Do you have TMJ or does your jaw click?	___	___
4. Do you currently have a cold?	___	___
5. Are you being treated for a thyroid disorder? Type_______	___	___
6. Do you have neck pain?	___	___
7. Do you have upper back pain?	___	___
8. Do you have a known history of carotid artery disease?	___	___
9. Do you have a family history of stroke?	___	___
10. Do you currently suffer with sinus problems?	___	___
11. Do you have history of dental problems?	___	___
Root canals ____ Gum disease ____ Implants ____		
Non-replaced extractions ____ Dentures ____		
12. Have you had dental cleaning in the past 7 days?	___	___
13. Have you been diagnosed with elevated cholesterol	___	___

Do you have any special concerns or are there any details related to the information above?

Chest, Heart & Lungs

	Yes	No
1. Have you been diagnosed with:		
Heart disease?	___	___
Lung disease?	___	___
Upper spine disorders?	___	___
2. Do you suffer with upper back pain?	___	___
3. Do you suffer with chest pain?	___	___
4. Have you been diagnosed with scoliosis?	___	___
5. Have you ever had surgery to your:		
Heart?	___	___
Lungs?	___	___
Mid to upper back?	___	___
6. Do you have asthma or shortness of breath?	___	___
7. Do you currently smoke?	___	___
8. Have you smoked in the past 5 years?	___	___
9. Do you suffer with shoulder pain? If yes; mark below	___	___

Do you have any special concerns or are there any details related to the information above?

Abdomen & Lower Back

1. Do you suffer with acid reflux or other digestive problems? Yes___ No___	3. Have you had surgery or disease in the:
2. Do you suffer pain in the:	Stomach? Yes___ No___
Stomach? Yes___ No___	Spleen(Upper Left) ? Yes___ No___
Below R Breast? Yes___ No___	Liver(Upper Right) ? Yes___ No___
Below L Breast? Yes___ No___	Kidneys ? Yes___ No___
Abdomen? Yes___ No___	Intestines ? Yes___ No___
Lower Back? Yes___ No___	Abdomen ? Yes___ No___
Pelvic Region? Yes___ No___	Lower Back? Yes___ No___
	Pelvic Region? Yes___ No___

4 Have you consumed alcohol in the past 24 hours? ___ ___

Legs & Feet

Check only if "Yes"

1. Do you suffer pain in the:	2. Have you had Surgery to:
Leg? LT___ RT___	Leg? LT___ RT___
Sciatica LT___ RT___	Sciatica? LT___ RT___
Buttocks/Hip? LT___ RT___	Buttocks/Hip? LT___ RT___
Knees? LT___ RT___	Knees? LT___ RT___
Ankles? LT___ RT___	Ankles? LT___ RT___
Feet? LT___ RT___	Feet? LT___ RT___

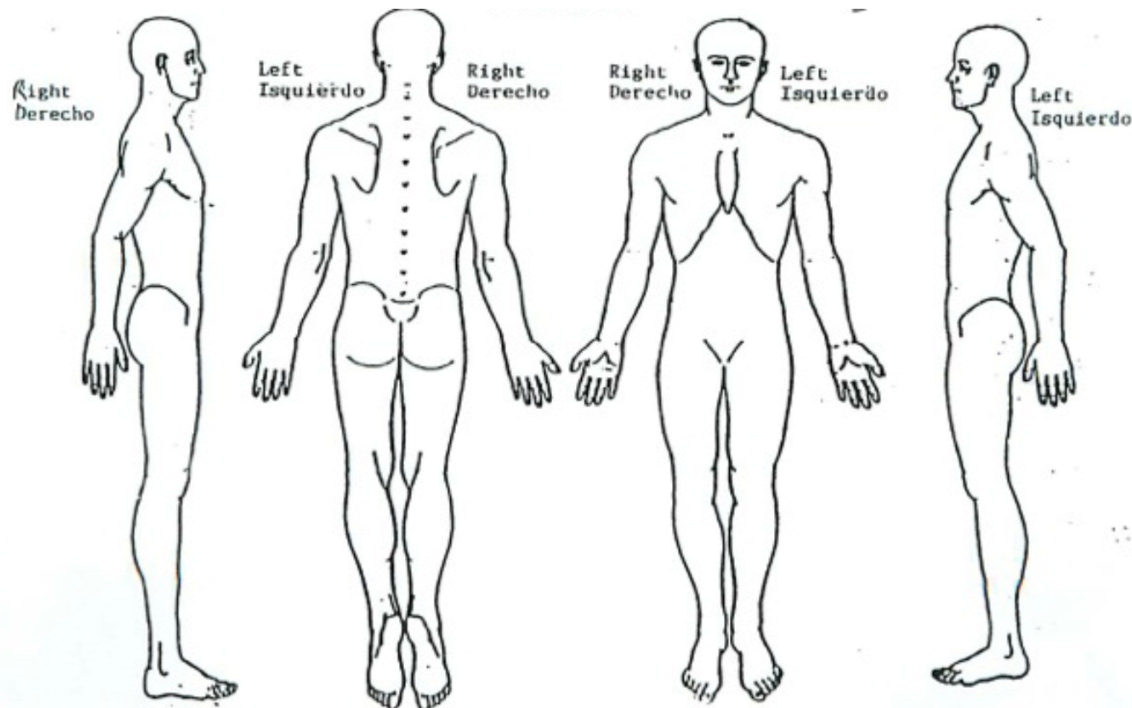
Do you have any special concerns or are there any details related to the information above?

Arms & Hands

Check only if "Yes"

1. Do you suffer with pain in the:	**LT**	**RT**	**2.** Have you had surgery to:	**LT**	**RT**
Shoulder?	___	___	Shoulder?	___	___
Elbow?	___	___	Elbow?	___	___
Arm?	___	___	Arm?	___	___
Hands?	___	___	Hands?	___	___

Areas of Pain



Areas of Pain

Do you have any special concerns or are there any details related to the information above?

Client Disclosure

Breast thermography is a non-contact, private and non-invasive procedure. The value of thermography as a study tool is its ability to measure skin temperature changes**. It offers men and women information that no other procedure can provide regarding inflammation.**

Procedure: You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment

Client Disclosure: I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self- evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, but will be an analysis of the images with respect only to the thermographic findings discussed in the report.

By Signing below, I certify that I have read and understand the statement above and consent to the examination. I am not an undercover agent or acting on behalf of law enforcement.

Client Signature ____ Today's Date_______________