Thermography CLINIC KITCHENER INC.

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FULL BODY & PAIN HISTORY

Name: ________________________________ Age: _____ Sex: _______ Date of Birth:______________

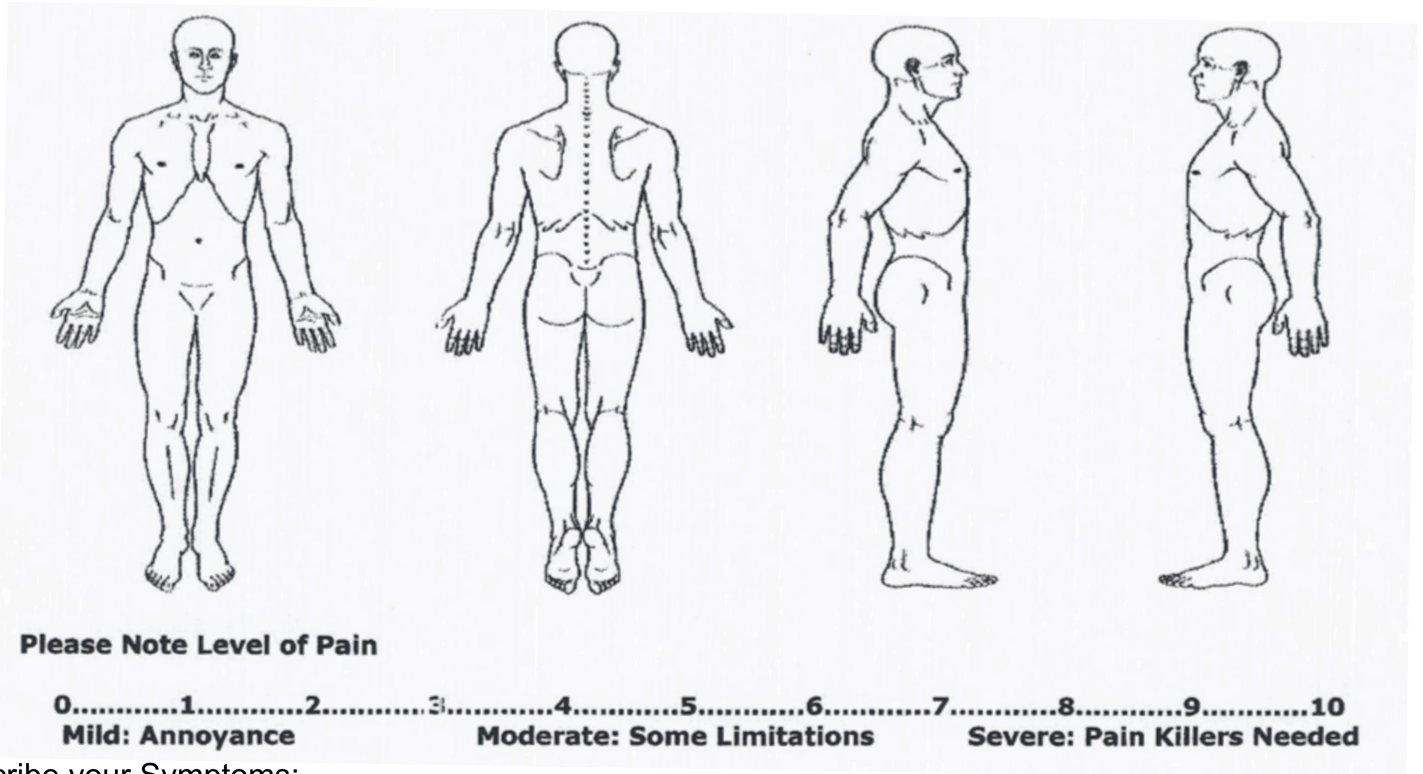
Address: ______________________________ City: __________________ Postal Code ____________

Home Tel: ___________________ Work Tel: ____________________ Occupation: ________________

E-mail ___________________________ Marital Status: Single Married Common Law Divorced Widowed Separated

Referred by: ____

Mark the location of symptoms with an "X" and label is as sharp, dull, burning, aching etc.:



Describe your Symptoms:____

____

____

When did this start?____

Were you examined for this complaint? *Y*☐ *N*☐ *Date and Results:*___________________________

____

____

What increases your symptoms?:____

____

What decreases your symptoms?:____

____

List any treatments you've had related to this condition:_____________________________

____

List any past surgeries related to your concern:________________________________

____

____

List any other medical conditions:____

____

____

What medications are you taking?:____

____

____

____

List and describe the location of any rash or markings on your body:_________________

____

____

Release for Testing Procedure

Thermal imaging provides physiological and functional diagnostic information and does not replace any other diagnositc 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 (for office use only)

INITIAL EXAM: ☐ RE-EXAM ☐ TECHNICIAN:___________________________________

Patient T = ______F Laboratory Temperature: _______C