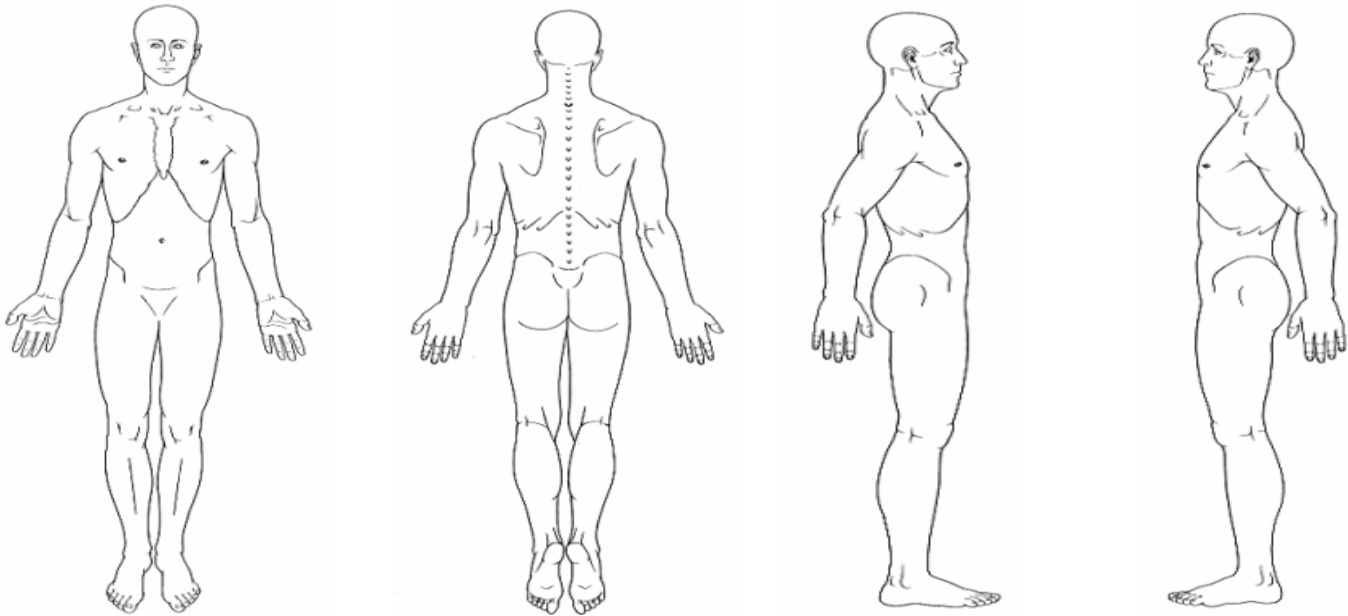


# Full Body and Pain History

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? \_\_\_\_\_

What medications are you taking? \_\_\_\_\_

List any treatments you have had: \_\_\_\_\_

List any other medical conditions: \_\_\_\_\_

List any past surgeries: \_\_\_\_\_

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

Practitioner in charge of your health: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Zip \_\_\_\_\_

May we send him or her your report?  Y  N

### 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** \_\_\_\_\_

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#### Please do not write in this section

Initial Exam       Re-Exam      Tech \_\_\_\_\_

Patient T = \_\_\_\_\_ F      Laboratory Temperature \_\_\_\_\_ C

Additional info: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_