# 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.*

## *Head & Neck*

| | Yes | No |
|---|---|---|
| 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___ |

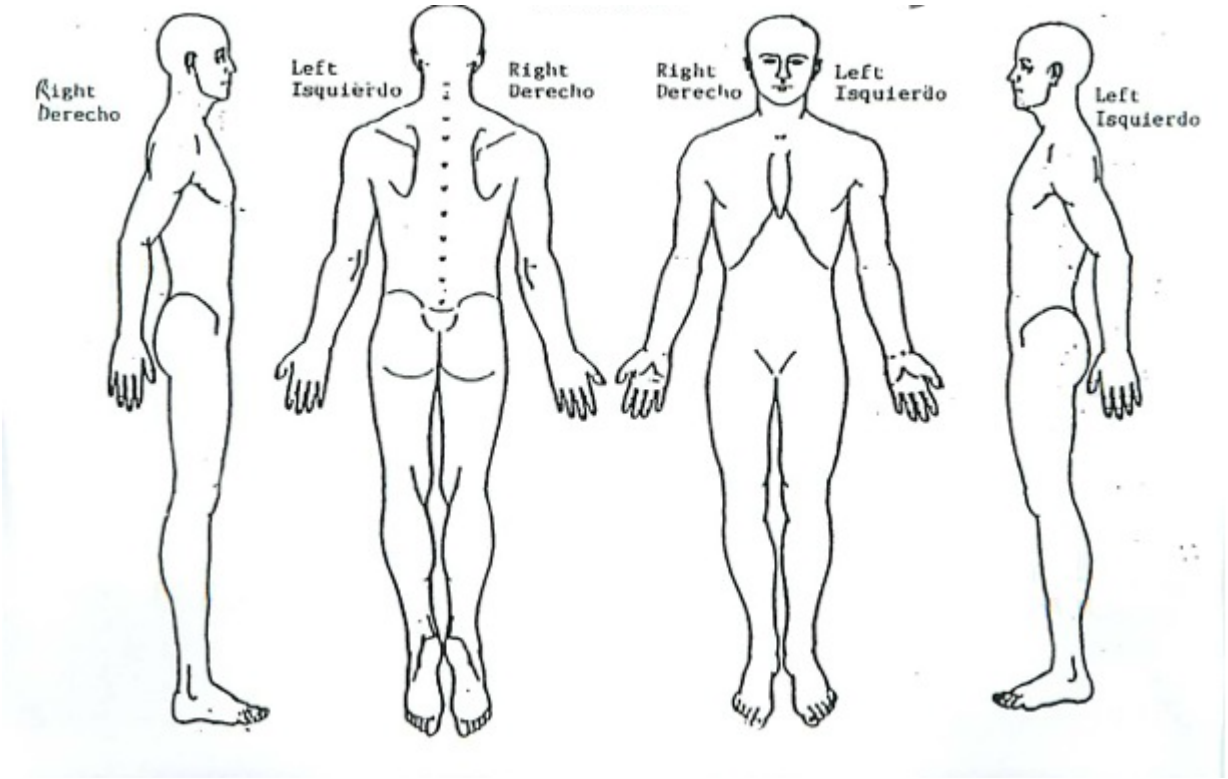
| Do you have any special concerns or are there any details related to the information above? |
|---|
| |

## *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**

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 general health.**

Thermography captures and records temperature variations on the skin, which provides vital information directly influenced by complex metabolic and vascular activity. This information **does not in any way suggest diagnosis and/or treatment**. Studies show that the patient benefits when multiple tests are used together. This multimodal approach includes breast self-examinations, physical breast exams by a doctor, mammography, ultrasound, MRI and other tests that may be ordered by your doctor.

**Notice to clients presenting with previously diagnosed cancer**: Thermography interpretation in your report **does not include information or recommendations related to the measured changes of disease beyond skin temperature changes and patterns**. As there is no single known test capable of monitoring all biological influences of the complex disease generally diagnosed as cancer, **continued monitoring with available additional testing as recommended by your personal physician is strongly advised.** Your Thermographer may not be a licensed medical professional. **Your Thermographer cannot interpret your images or advise or prescribe to you based on your images.** Your thermographer can ask health history questions as well as educate you on general breast health.

*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_____