Picture of Health Thermograms
Region of Interest / Special Study Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting thermologist, your referring physician and any other practitioner that you specify.

Name:_____**Birthdate**_____

Address:_____

City, State. Zip_____

Name of Physician_____

Phone or email address of your doctor_____

Please Show areas of :

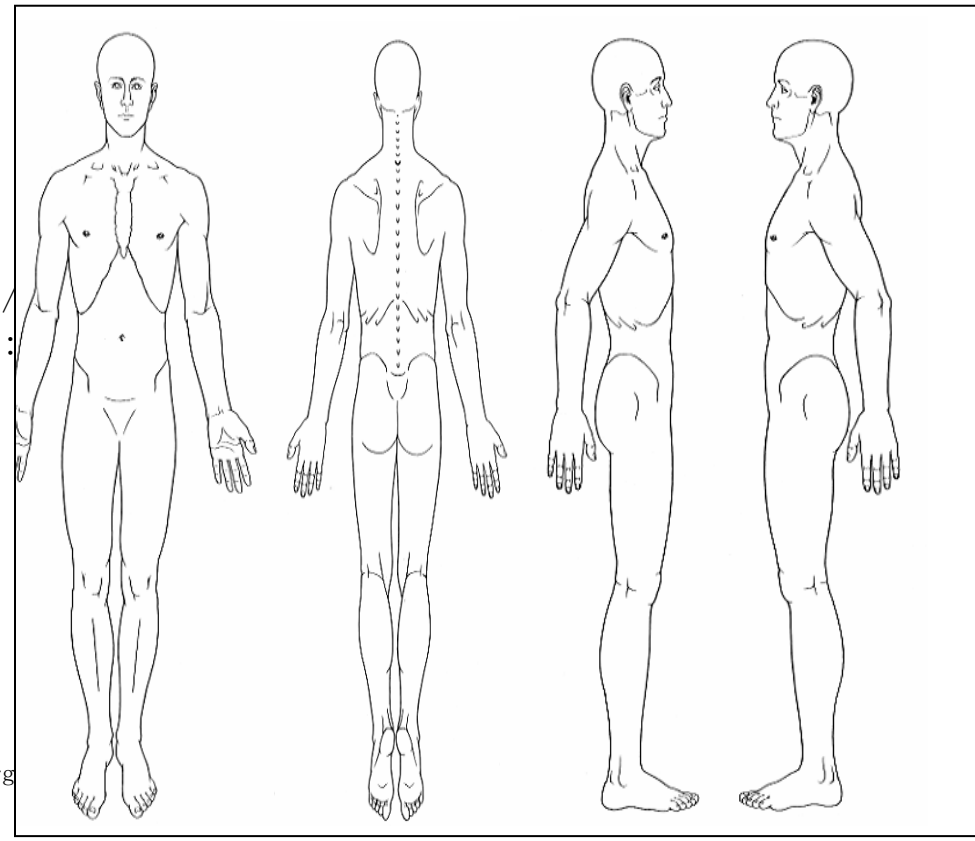
Main Pain *

Secondary Pain ○

Numbness ////

Pins and needles ::::::

Skin lesions / scaring



Do you know what triggered the pain ?

Does anything relieve it ?

_____

Does anything aggravate it ?

_____

Has it changed since it began ?

_____

Have you had any treatment ?

_____

History: Injuries / Fractures / Surg

_____

Patient remarks:

_____

_____

_____

_____

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report **is not intended to be used by individuals for self evaluation** or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings of the areas discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature ……..