Confidential Questionnaire

Lower Body Pain Study

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. ***This is a specific pain study, so questions related to other conditions are grayed out. If a more comprehensive health study is desired, choose a Health Study instead.***

Lower Back Related Pain

1. Do you suffer with acid reflux or other digestive problems? Yes___ No___	3. Have you had surgery to these areas? Provide more details below:
2. Do you suffer pain in the:	Stomach? Yes___ No___
Stomach? Yes___ No___	Spleen(Upper Left) ? Yes___ No___
R Rib Area? Yes___ No___	Liver(Upper Right) ? Yes___ No___
L Rib Area? 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___

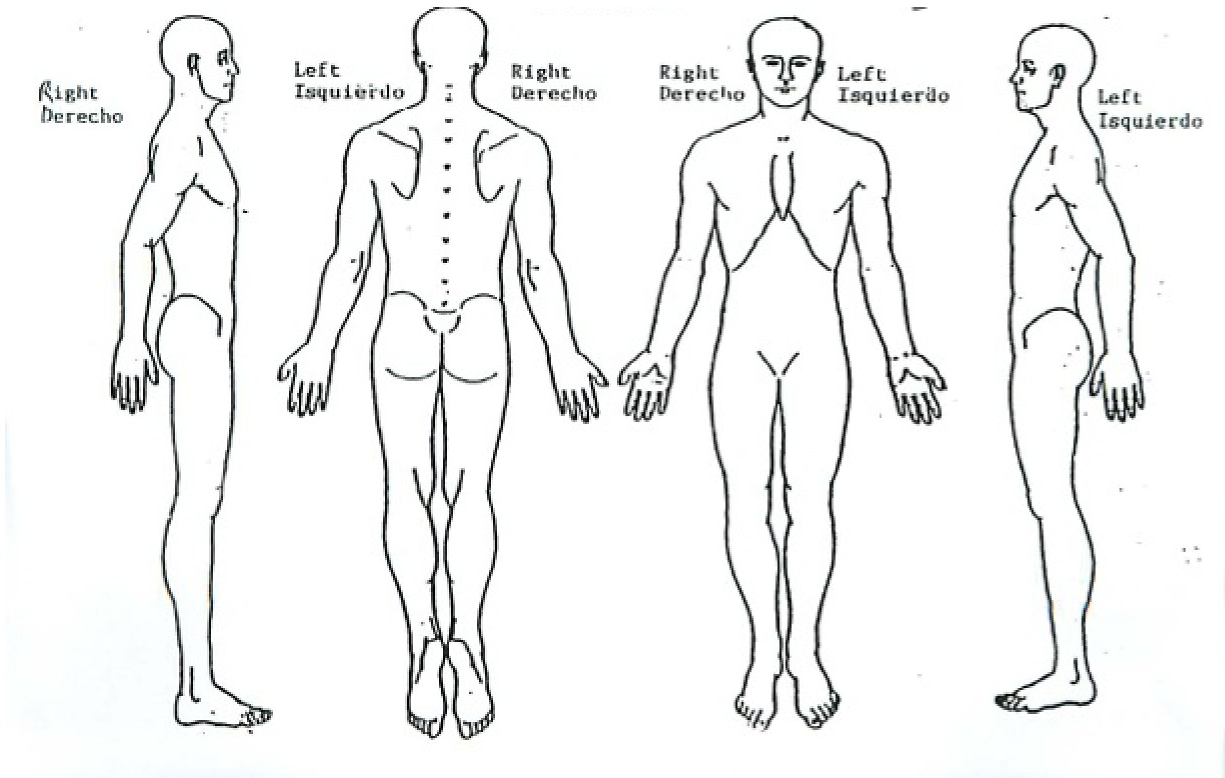
Lower Extremities Related Pain

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 ___

See area below for additional information or concerns. Please provide dates and specific details related to surgery or previous treatments.

Mark Areas of Pain with Description (burning, stabling, aching) and duration (chronic = more than 6 months)



Areas of Pain

Do you have any special concerns or are there any details related to the information above? Please provide dates and specific details related to surgeries or treatments.

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 suggesting inflammatory response to injury or metabolic effects of tissue disturbance**. It offers men and women supportive information that no other procedure can provide regarding general health.**

This information **does not in any way suggest diagnosis and/or treatment**. Studies show that the patient benefits when multiple tests are used in combination. This multimodal approach includes physical exams by a licensed healthcare provider, ultrasound, MRI and other tests that may be ordered by your doctor.

Notice to clients presenting with previously diagnosed conditions including 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 diseases, **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_______________