Thermal Imaging Consultation

Surname_____ First name_____

Address_____

Phone number_____ Email_____

Consultation date_____ Date of birth_____Age____

Occupation_____

Doctor_____Other_____

Health Concerns _____

_____

_____

_____

Treatments (Chiropractic)_____

Medications _____

Supplements _____

Sugeries _____

_____

Rootcanals/crowns _____

Family Medical History _____

_____

Scaring/Skin abnormalities _____

Thermal Imaging is a non-contact investigation demonstrating physiological patterns of your body. It is not a stand alone diagnostic test. Thermal images provide evidence of thermal asymmetries that may be present which may indicate a vascular, neurological, muscular or other physiological problem.

I have read the above information and I understand that I am not receiving a diagnosis of any condition based solely on my thermal scan. I understand that thermal imaging is non-invasive and is reading the thermal patterns on the surface of my body.

Signature_____ Date _____