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 _____Amalgams_____

Family Medical History _____

_____

Scaring/Skin abnormalities _____

You will receive you report copy in 5-7 working days.
Would you like a copy sent to your health care practioner? _____

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 _____

Specific Breast & Hormonal Health Questionnaire

1. Do you have any close relatives with breast cancer? Yes/No

Please specify _____

2. Have you ever been diagnosed with breast cancer? Yes/No

Month/Year _____ Breast right/left Area of breast _____

_____

Surgery _____ Chemo Radiation

3. Have you ever been diagnosed with any other breast disease? Yes/No

Mastitis Fibrocystic Cystic Other _____

4. Have you had surgeries biospies to the breasts? Yes/No

Lumpectomy Mastectomy Needle biopsy Breast right/left

5. Have you had cosmetic surgery or implants? Yes/No
6. Have you had a mammogram in the last 12 months? Yes/No
7. Have you had a mammogram in the last 5 years? Yes/No

How many mammograms in total _____ Age of first mammogram _____

8. Have you had any abnormal results from breast testing? Yes/No
9. Have you ever taken the contraceptive pill for more than a year? Yes/No

Age started _____ Years taken _____

10. Have you ever suffered from cancer of the womb? Yes/No
11. Have you ever had HRT? Yes/No

Please specify _____

12. Do you have an annual breast exam from your doctor? Yes/No
13. Do you perform a monthly breast self exam? Yes/No
14. Do you use anti-perspirant deodorants? Yes/No
15. Have you suffered trauma to the chest? Yes/No

Menstrual History

Age of onset _____ Period length in days _____ Length of monthly cycle _____

Day of cycle (today) _____

Are you menopausal? _____ Age on onset _____ Or date of last period _____

Hysterectomy: Yes/No Age_____ Ovaries removed: Yes/No

Pregnancies

Age first birth _____ Number of children _____ Breastfed: Yes/No

Have you ever been a smoker: Yes/No/Not in last 12 months/Not in last 5 years