# Confidential Questionnaire

## *Upper 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.***

## *Head & Neck Related Pain*

| | 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, Shoulder and Upper Back Related Pain*

| 1. Have you been diagnosed with: | Yes | No |
|---|---|---|
| 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?

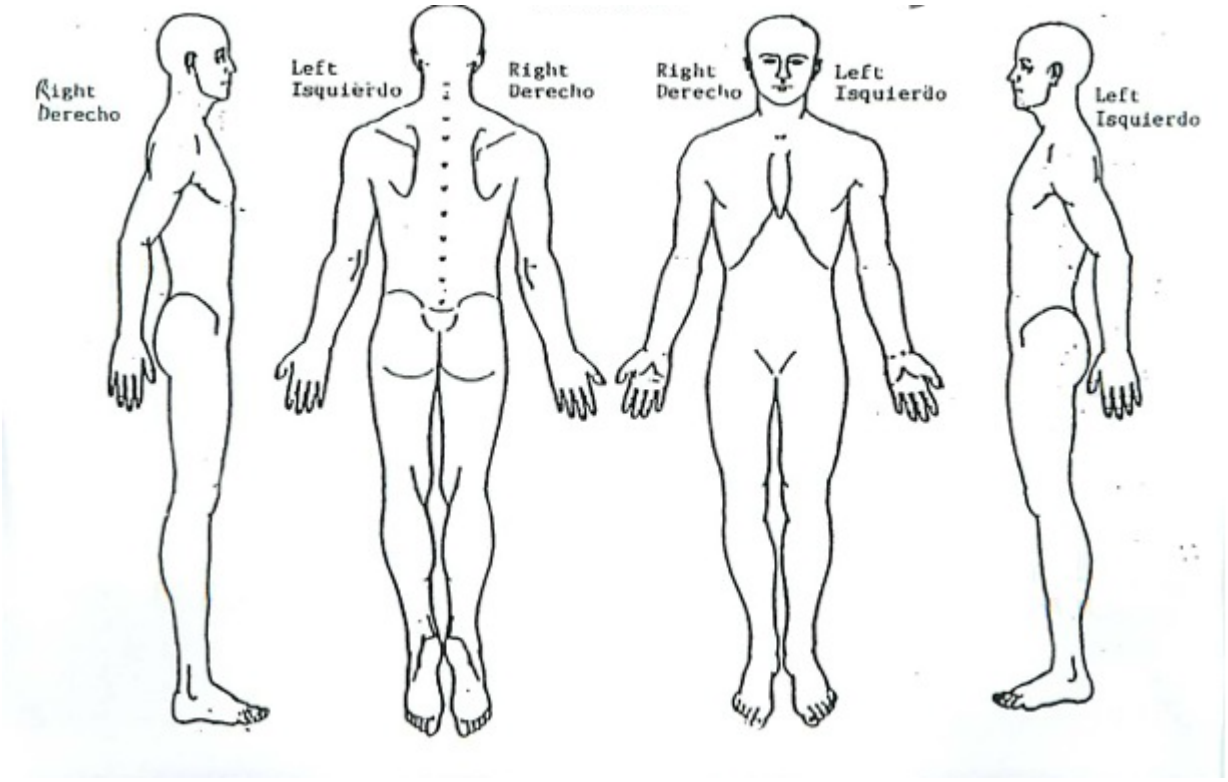
## *Upper Extremities Related Pain*

Check only if "Yes"

| 1. Do you suffer with pain in the: | LT | RT |
|---|---|---|
| Shoulder? | ____ | ____ |
| Elbow? | ____ | ____ |
| Arm? | ____ | ____ |
| Hands? | ____ | ____ |

| 2. Have you had surgery to: | LT | RT |
|---|---|---|
| Shoulder? | ____ | ____ |
| Elbow? | ____ | ____ |
| Arm? | ____ | ____ |
| Hands? | ____ | ____ |

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




***Areas of Pain***

| |
|---|
| Do you have any additional information or special concerns related to the information above?<br>Please provide dates and specific details related to surgeries or treatments. |

**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 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_____