All About Herbs Thermal Imaging New Client Intake Form

Name: _____

Date of Birth: _____Age: _____ Gender: _____

Street: _____

Town, State, Zip: _____

Phone Number: ( ) _____-_____

How did you hear about us? _____

_____

Current Concerns or Symptoms:

_____

_____

_____

Current Treatment:

_____

_____

_____

_____

Current medications: (Prescriptions only)

_____

_____

_____

_____

Diagnosed medical problems: (high blood pressure, diabetes, arthritis, cancer, etc)

_____

_____

_____

Infusion port or internal device? (Breast thermals will need to be rescheduled 90 days after port is removed)

_____

Previous surgeries or Biopsies / Dates:

_____

_____

Dental History:

Amalgams? yes___ no___ #_____

Fillings? yes_____ no_____ #_____

Bridge? yes_____ no_____ #_____

Root Canal? yes_____ no_____ #_____

Skin Lesions or Physical Abnormalities: (scars, birthmarks, bone deformities, structural asymmetry)

Family Medical History: (cancer, cardiovascular diseases, diabetes, stroke, etc)

Female Patient Only

Ob/Gyn History:

Mammogram/Ultrasound history:

Any notes that you might have about yourself that could better help us help you:

This information is confidential.
All information is correct and current to my knowledge.
No medical information has been intentionally been omitted for the purpose of this report.
Doctors need full disclosure to make an accurate reading.
Thermograms are not a replacement for mammograms.
*Please call **907-376-8327** if you have questions or need to reschedule.*

Signature: _____ Date: _____

Thermographer: _____