Thermography Medical Clinic
The Future of Preventative Healthcare...Today!

Physicians INSIGHT Clinical Interpretation

Confidential Questionnaire – Cranial / Dental Assessment

Patient's Name	**Report Date**
D.O.B.	**Referring Physician**
Address	**City**
Province	**Postal Code**
Home Phone	**Cellular Phone**
Work Phone	**E-Mail**

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.*

	YES	NO
Are you currently taking any supplements; if yes please list	◯	◯
Are you currently taking any medication; if yes please list	◯	◯
Are you using bio identical hormones?		
☐ Progesterone		
☐ Estrogen		
☐ DHEA		
☐ Testosterone		

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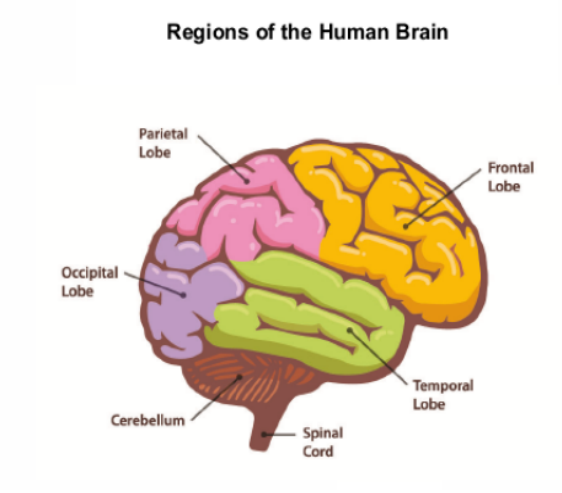
HEAD & NECK

	YES	NO
Do you suffer with headaches?	◯	◯
If yes, ◯ once a month or less ◯ more than once a month		
Is it: ☐ Dull ☐ Sharp ☐ Cluster ☐ Sinus ☐ Other _____		
Location: ☐ Right ☐ Left ☐ Frontal Lobe ☐ Parietal Lobe ☐ Temporal Lobe ☐ Occipital Lobe		
Do you have allergies?	◯	◯
If yes: ☐ Seasonal ☐ Hay fever ☐ Food ☐ Dust ☐ Mold ☐ Pets ☐ Unknown		
Do you currently have a cold?	◯	◯
Are you being treated for a thyroid disorder?	◯	◯
Is it: ☐ Hypo ☐ Hyper ☐ Hashimoto's ☐ Grave's ☐ Goiter ☐ Cancer ☐ Unknown		
Have you been diagnosed with cerebral circulatory problems?	◯	◯
If yes, please explain:		
Do you have neck pain?	◯	◯
Do you have upper back pain?	◯	◯
Do you have a history of carotid artery disease?	◯	◯
Do you have a family history of stroke?	◯	◯
Do you currently suffer with sinus problems?	◯	◯



Do you have any special concerns or any details related to the information above?

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DENTAL	YES	NO
Do you have a specific dental concern?	◯	◯
If yes, describe:		
Do you have dental examinations on a regular basis?	◯	◯
Date of last visit:		
Have you ever been diagnosed with TMJ (Temporal Mandibular Joint) Disorder?	◯	◯
Have you ever had root canal treatments?	◯	◯
☐ Upper Left ☐ Upper Right ☐ Lower Left ☐ Lower Right		
Do your gums ever bleed?	◯	◯
Do you clench or grind your teeth?	◯	◯
Does your jaw hurt or click?	◯	◯
◯ Right ◯ Left		
Do you have difficulty chewing?	◯	◯
Do you think you have active decay or gum disease?	◯	◯

Do you have any special concerns or any details related to the information above?

Procedure: *You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.*

Patient Disclosure: *I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, but will be an analysis of the images with respect only to the thermographic findings discussed in the report.*

By signing below, I certify that I have read and understand the statement above and consent to the examination.

Patient Signature _____ Today's Date _____