Confidential Questionnaire

Abdomen and Lower Back Health Screening

First Name _____ Middle Initial_____ Last Name _____
Date of Birth ____/___/_____ Age _____
Address_____ City_____ State_____ Zip_____
Home Phone# _____ Work Phone#_____ Cell Phone#_____
Email_____
Please tell us how you heard about Carolina Thermascan_____
Location of scan (please circle):

Raleigh Greensboro Wilmington – Restore Health & Wellness Center Wilmington-ChiroCynergy

Are you a patient at any of any providers at the above locations? Yes____ No ____ If so, we will provide a copy of your report to that practitioner. Name of Provider: _____

Were you referred by another health care practitioner? Yes____ No ____ If so, we will send a copy of your scan and report to that practitioner. Please provide:
_____
_____

CURRENT MEDICATIONS AND SUPPLEMENTS:

Medications: _____
_____
_____
Supplements: _____
_____
_____

Abdomen & Lower Back

	Yes	No		Yes	No
1. Do you suffer with acid reflux or other digestive problems?	Yes___	No___	Have you had surgery or disease in the:		
2. Do you suffer pain in the:			Stomach?	Yes___	No___
Stomach?	Yes___	No___	Spleen(Upper Left) ?	Yes___	No___
Below R Breast?	Yes___	No___	Liver(Upper Right) ?	Yes___	No___
Below L Breast?	Yes___	No___	Kidneys ?	Yes___	No___
Abdomen?	Yes___	No___	Intestines ?	Yes___	No___
Lower Back?	Yes___	No___	Abdomen ?	Yes___	No___
Pelvic Region?	Yes___	No___	Lower Back?	Yes___	No___
			Pelvic Region?	Yes___	No___

Have you consumed alcohol in the past 24 hours? Yes___ No___

Do you have any special concerns or are there 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 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 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.

Client Signature_____ Today's Date_____