Confidential Questionnaire

Chest and Lungs 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: _____
_____
_____

Chest, Heart & Lungs

		Yes	No
1. Have you been diagnosed with:			
	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 ever had surgery to your:		**Yes**	**No**
	Heart?	___	___
	Lungs?	___	___
	Mid to upper back?	___	___
5. Do you have asthma or shortness of breath?		___	___
6. Do you currently smoke?		___	___
7. Have you smoked in the past 5 years?		___	___

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_____