Confidential Questionnaire

Head and Neck 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: _____
_____
_____

	Yes	No
Head & Neck		
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 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_____