BOSTON THERMOGRAPHY CENTER, INC.

BostonThermography.com
617-389-3828

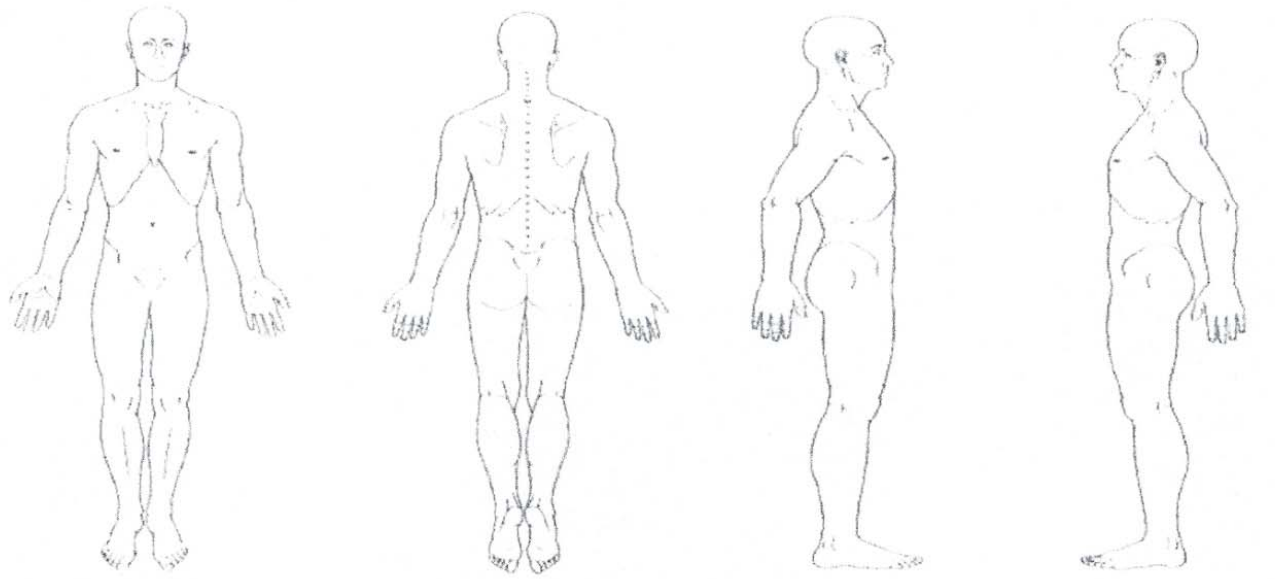
Full Body & Pain History

Date: _____ Date of Birth: _____

Name: _____Address:_____

City: _____State: _____Zip Code: _____

Mark the location of symptoms with an "X" and label it as sharp, dull, burning, aching, etc.



Please Note Level of Pain

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10
Mild: Annoyance **Moderate: Some Limitations** **Severe: Pain Killers Needed**

Describe your symptoms: _____

_____

How and when did this start? _____

_____

Were you examined for this complaint? _____ Date and Results: _____

_____

What increases your symptoms? _____

_____

What decreases your symptoms? _____

_____

List any treatments you have had: _____

_____

List any past surgeries especially related to your concern: _____

_____

List any other medical conditions:_____

_____

What medications are you taking? _____

_____

List and describe the location of any rash or making on your body: _____

_____

Release for Testing Procedure

Thermal Imaging provides physiological and functional diagnostic information and does not replace any other diagnostic procedure.

I have read the above information and understand that I am not receiving a diagnosis based on my thermal scan. I authorize the clinic's personnel to perform this and all subsequent thermal imaging examinations.

_____ _____

Signature Date Print Name

Please do not write in this section

☐ Initial Exam ☐ Re-Exam Tech _____

Patient T = _____F Lab Temperature _____F