Healthworks
NUTRITION CENTRE

FULL BODY – INITIAL VISIT

Name:_____Date: _____

Address: _____City:_____Province:_____PC:_____

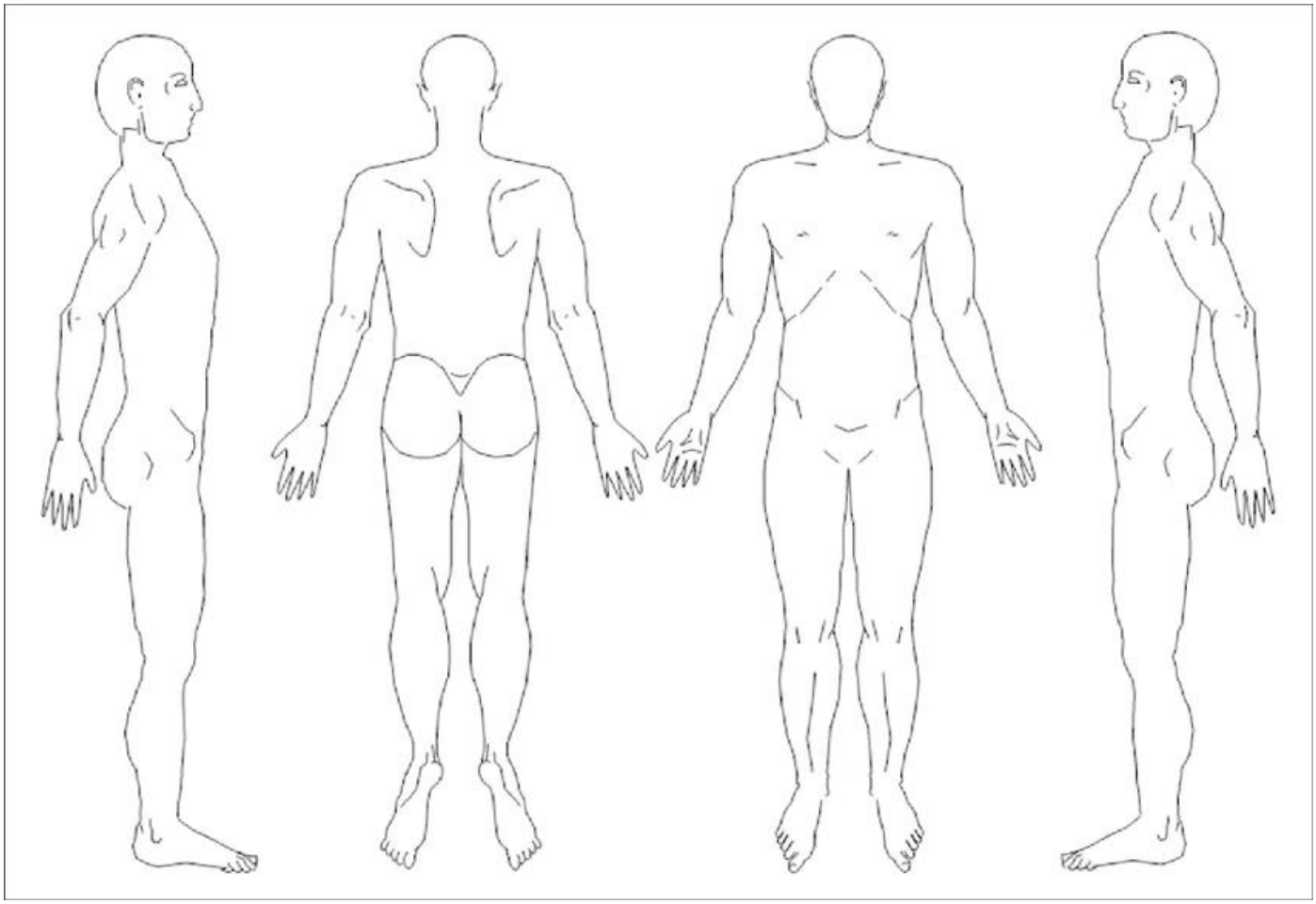
Phone:Cell: _____Work:_____Home:_____

Occupation: _____Hours/week:_____Retired?_____

Email: _____ D.O.B: mo / day / year

Emergency Contact #:_____Emergency Contact Relation:_____

Occupation: _____ Marital Status: S M D W SEP # of Children: _____



Mark the location of your symptoms with and "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

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Describe your symptoms: _____

_____

_____

_____

How and when did this start: _____

Were you examined for this complaint: ❒ Y ❒ N Dates: _____

Results: _____

What increases your symptoms: _____

What decreases your symptoms: _____

Treatments:	Related past surgeries:	Other medical conditions:	Medications:	Describe the location of a rash or marking on your body:

Release for Test 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 this clinic's personnel to perform this and all subsequent thermal imaging exams.

I have complied with the pre-examination instructions for proper thermal imaging.

Name: _____ Date: _____

Signature: _____

For clinic use only:

❒ Initial Exam ❒ Re-Exam Patient Temp. _____ F Clinic Temp. _____C

Clinician: _____