Lower Body Study Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Name: _____ **D.O.B:** _____

Address: _____

Phone: _____ **Your Doctor:** _____

Please Show areas of :

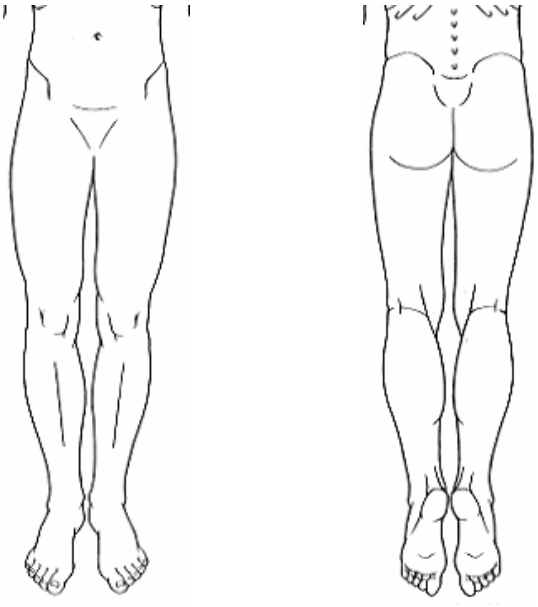
Main Pain *

Secondary Pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions / scaring ↗



Do you know what triggered the pain ? _____

Does anything relieve it ? _____

Does anything aggravate it ? _____

Has it changed since it began ? _____

Have you had any treatment ? _____

History: Injuries / Fractures / Surgery

Patient Disclaimer

I acknowledge that I have read and understood the patient information regarding Digital Infrared Thermal Imaging and consent to the examination.

Patient's Name : .....… Signed : Date :