

Region of Interest / Special 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



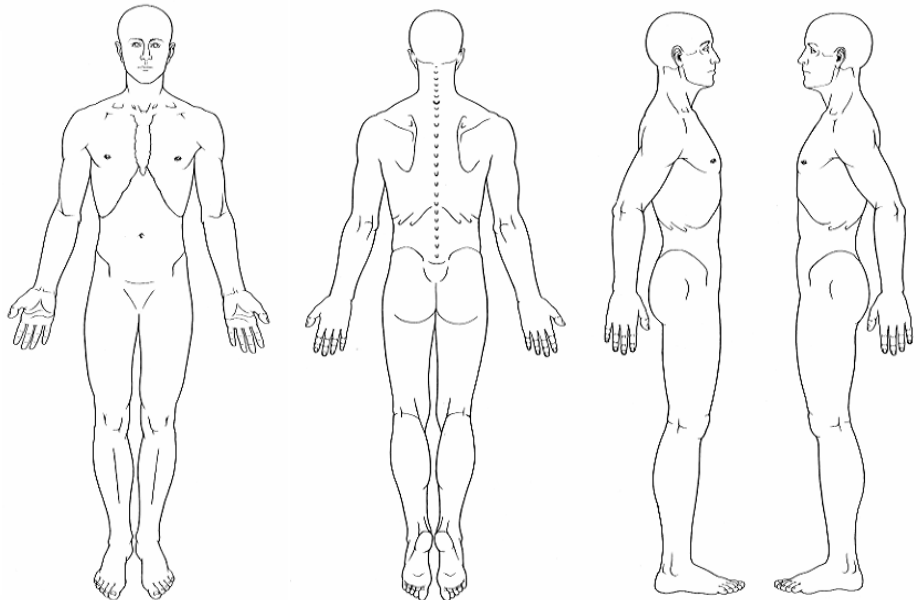
Numbness



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 : _____