Thermography Patient Intake Form

Natural Wellness Center

Name ____
DOB _____________ Age ___________
Street ____
Town ____
State, Zip ____
Occupation ________________________
E-mail ____

Patient ID# ______________ Next Appt.____________
Report Ref # _____________ BR1 BR2 BRA HB FB ROI
Referred by ____________________________________
Location _____________ Scans uploaded____________
Data updated ___________ called _________________
SOC___ Pt rpt sent_________ HCP rpt sent _________
Pymt ___________ ck #___________ V MC DISC

Phone (also area code) (H) __________________
(W) ___________________ (Cell)_________________(F)________________

Leave message w/results? Yes / No
Reason for today's visit: ____
Current Symptoms: ____
____
CurrentTreatment:____
____
Illnesses:____
____
Previous Surgeries/Dates: ____
____
Injuries/Dates: ____
____
Current Medication(s): ____
____

This information is confidential and correct to my knowledge.
Signed: __________________________________ Date: _____________________

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