

PICTURE MY HEALTH, LLC

952-926-2511

Thermography, the safe way to screen

CLIENT INTAKE FORM

(All information is confidential)

Name: (PLEASE PRINT CLEARLY) _____ DOB: _____ Age: _____

Mailing Address: _____

City/State/Zip: _____ *Please indicate if it is ok to

Phone: Home (____) _____ Cell (____) _____ leave a voicemail: YES / NO

Email: _____ Occupation: _____

(For results and reminders ONLY; we DO NOT give out personal information)

Main concern today: _____

Symptoms/onset: _____ **Treatment:** _____

_____	_____
_____	_____
_____	_____
_____	_____

Dental Work (root canals/crowns/fillings/extractions including wisdom/braces/mouth trauma; where and how many):

Previous illnesses/conditions:

_____ Date: _____

_____ Date: _____

Previous surgeries and injuries:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Other screening tests/results in last 5 yrs:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Family History:

Scars/Tattoos:

Current Medications:

_____	Dose: _____	How long? _____
_____	Dose: _____	How long? _____
_____	Dose: _____	How long? _____

TO THE BEST OF MY KNOWLEDGE, ALL INFORMATION IS CORRECT (Please sign below):

➤ Signed: _____ Screening Date: _____

Disclaimer: Picture My Health, LLC does not claim thermography replaces mammography.

For office use only: VZ SP CK CB RW		PictureMyHealth.com
BR1 BR2 BRA FB UB LB ROI	PT ID# _____	Rep. Ref# _____
Referred by: _____		Location: _____
Next appt: _____		
EMI: _____	Rept. Sent _____	PT EM DR. _____
Called _____		LM/TT Updated: _____
Payment: \$ _____	Ck# _____	Credit: V MC AM D CA
Rcpt: Y / N		mailed _____
rcv'd _____		
Updated 080824		