

# 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? _____
_____	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 JW CK AM LL

PictureMyHealth.com

BR1 BR2 BRA FB UB LB ROI PT ID# \_\_\_\_\_ Rep. Ref# \_\_\_\_\_ Location: \_\_\_\_\_

Referred by: \_\_\_\_\_ 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 062019