PICTURE MY HEALTH, LLC

952-926-2511

Thermography, the safe way to screen CLIENT INTAKE FORM

(All information is confidential)

Walting Address: City/State/Zip: Please indicate if it is ok to leave a voicemail: YES / NO Crail: Per 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): Dental Work (root canals/crowns/fillings/extractions including wisdom/braces/mouth trauma; where and how many): Date: Treatment: Date: Date: Date: D	Name: (PLEASE PRINT CLEARLY)			DOB:	Age:
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