

Hindsight Thermography Clinic

25 Flume Drive, Middle Sackville, NS B4E 3H1 (902) 869-0203 or (902) 237-0908

Name: Address:	Date of Birth (m/d/y)					
Phone: Email:	(H)	(B)	(C)			
	(H)					
Please no	te level of pain					
O Mild: An	-12 noyance	35 Moderate: Some limitations	-67 Sev	810 vere: Pain killers needed		
Describe	your symptoms:					
How and	when did this start):				
Were you	examined for this?	Y/N If yes, date and results:				
What inc	reases your sympton	ms?:				
What dec	reases your sympto	ms?:				



List any treatments you have had:							
List any surgeries, especially related to your concern:							
List any other medi	cal conditions:						
List any medication	s you are taking:						
List and describe th	e locations of any ras	sh or makings on y	vour body:				
******	*******	*******	******				
	Release	for testing Prod	cedure				
Thermal Imaging provides physiological and functional diagnostic information and does not replace any other diagnostic procedure.							
	authorize this clinic'		m not receiving a diagnosis based on form this and all subsequent thermal				
I have complied wit	h the pre-examinatio	on instructions for	proper thermal imaging.				
Drint name:							
Print name:							
Signature:		 					
Date:							
	Please do	o not write in this	section				
Digital Exam:	D Re-Exam:	Tech:	Patient T:F				
Laboratory Temperature							