CWC | Crossroads Wellness Center

Confidential Questionnaire

Women's Full Body

Name _____ Birth Date _____ Today's Date_____

Address _____ City _____ State ____ Zip _____

Phone Number (home)_____(cellular)_____(work)_____

Email Address _____ Referring Physician _____

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermographer and any other practitioner that you specify.

Head & Neck

	Yes	No
1. Do you suffer with headaches?	___	___
If yes, once a month or less ____ more than one a month ____		
2. Do you have known allergies? Food ____ Environmental ____	___	___
3. Do you have TMJ or joes your jaw click?	___	___
4. Do you currently have a cold?	___	___
5. Are you being treated for a thyroid disorder? Type _____	___	___
6. Do you have neck pain?	___	___
7. Do you have upper back pain?	___	___
8. Do you have a history of carotid artery disease?	___	___
9. Do you have a family history of stroke?	___	___
10. DO you currently suffer with sinus problems?	___	___
11. Do you have history of dental problems?	___	___
Root Canals ____ Gum Disease ____ Implants ____		
Non-Replaced Extractions ____ Dentures ____		
12. Have you had a dental cleaning in the past 7 days?	___	___
13. Have you been diagnosed with elevated cholesterol?	___	___

Do you have any special concerns or are there any details related to the information above?

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Breast

Is there a specific reason or concern for this breast exam?

Yes **No**

1. Have you recently had any of these breast symptoms? (Mark only if "Yes") ___ ___
   - Pain/Tenderness RT___ LT___
   - Lumps RT___ LT___
   - Change in breast size RT___ LT___
   - Areas of skin changing, thickening or dimpling RT___ LT___
2. Are any of the above symptoms cycle related? ___ ___
3. Are you still having periods? If yes, date of last period _____ ___ ___
4. Have you had a surgical hysterectomy? ___ ___

   If yes, date _____ Complete ___ Partial ___

   Reason for hysterectomy (Circle)

   Excess Bleeding Endometriosis Fibroid Cysts Cancer Other _____
5. Has anyone in your family ever been treated for breast cancer? ___ ___

   If yes, circle: Mother Grandmother Sister Daughter

   Age Diagnosed _____ Result of Treatment _____
6. Have you ever been diagnosed with breast cancer? ___ ___

   If yes, date: Month _____ Year _____

   Cancer Type (Circle): Local Metastatic Lymph Node Involvement

   Left Breast: Inner Outer Nipple

   Right Breast: Inner Outer Nipple

   Treatment: Surgery Chemo Radiation None Other _____

   If Surgery: Mastectomy Lumpectomy
7. Have you ever been diagnosed with any other breast disease? ___ ___

   If yes, cysts/fibrocystic ___ Fibro Adenoma ___ Mastitis/Inflammatory breast disease ___
8. Have you had any cosmetic breast surgery or implants? ___ ___

   If yes, date _____ Type (circle): Silicone Saline

   Experience (circle): No problems Problems _____

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9. Have you ever had any biopsies or any other surgeries to your breasts? ___ ___

   If yes, date: _____

Left Breast:	Inner	Outer	Nipple
Right Breast:	Inner	Outer	Nipple
Results:	Negative	Positive	Calcifications

10. Have you ever taken contraceptive pills for more than one year? ___ ___

    If yes, circle: Currently Less than 5 years More than 5 years

11. Have you had pharmaceutical hormone replacement therapy (HRT)? ___ ___

    If yes, circle: Currently Less than 5 years More than 5 years

12. Do you have an annual physical examination by a doctor? ___ ___

13. Do you perform a monthly breast self-exam? ___ ___

14. Have you ever smoked? ___ ___

15. Have you ever been diagnosed with diabetes? ___ ___

16. Have you had a mammogram? Number of mammograms ____ ___ ___

17. Date of last mammogram _____ Were you re-called? ___ ___

18. Your age at your first mammogram: _____

19. Number of full-term pregnancies? _____

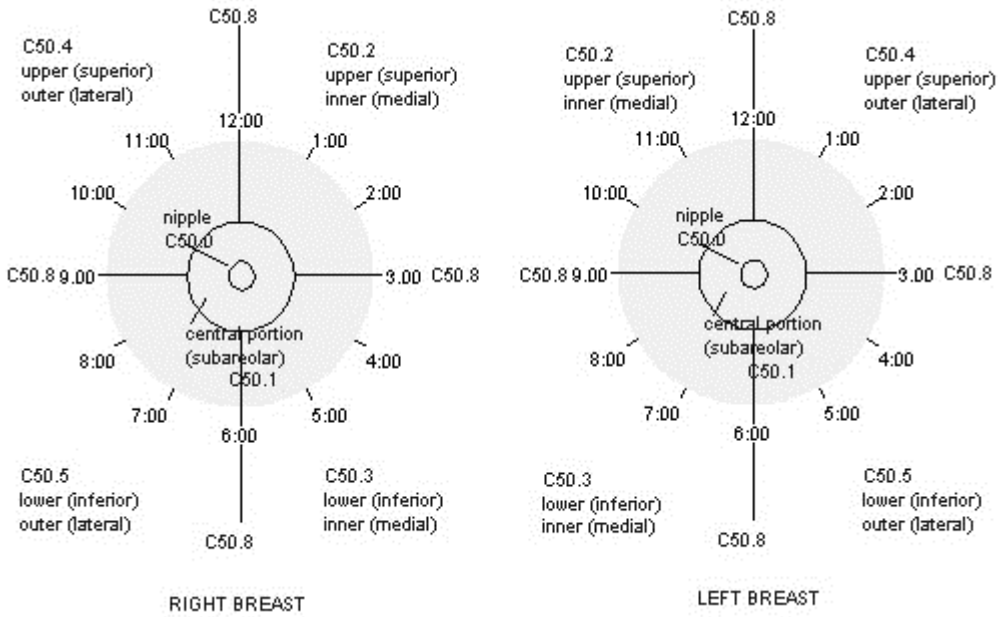
20. Have you had a breast ultrasound? ___ ___

    If yes, date _____ Left ____ Right____ Results: Negative____ Positive____

21. Have you had a breast MRI? ___ ___

    If yes, date _____ Left ____ Right____ Results: Negative____ Positive____

Mark on the following graph to indicate location of pain, surgery, or lumps:



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Chest, Heart, & Lungs

	Yes	No
1. Have you been diagnosed with…		
a. Heart Disease?	___	___
b. Lung Disease?	___	___
c. Upper Spine Disorders?	___	___
2. Do you suffer with upper back pain?	___	___
3. Do you suffer with chest pain?	___	___
4. Have you ever been diagnosed with scoliosis?	___	___
5. Have you ever had surgery to your…		
a. Heart?	___	___
b. Lungs?	___	___
c. Mid to Upper Back?	___	___
6. Do you have asthma or shortness of breath?	___	___
7. Do you currently smoke?	___	___
8. Have you smoked in the past 5 years?	___	___
9. Do you suffer from shoulder pain?	___	___

Do you have any special concerns or are there any details related to the information above?

Abdomen & Lower Back

1. Do you suffer with acid reflux or other digestive problems? Y___ N___
2. Do you suffer pain in the…

Stomach?	Y___ N___
Below R Breast?	Y___ N___
Below L Breast?	Y___ N___
Abdomen?	Y___ N___
Lower Back?	Y___ N___
Pelvic Region?	Y___ N___

3. Have you had surgery or disease in the…

Stomach?	Y___ N___
Spleen (Upper Left)?	Y___ N___
Liver (Upper Right)?	Y___ N___
Kidneys?	Y___ N___
Intestines?	Y___ N___
Abdomen?	Y___ N___
Lower Back?	Y___ N___
Pelvic Region?	Y___ N___

4. Have you consumed alcohol in the past 24 hours? Y___ N___

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Lower Extremities Related Pain

Check only if "Yes"

1. Do you suffer pain in the…

Leg?	LT___ RT___	3. Leg?	LT___ RT___
Sciatica?	LT___ RT___	4. Sciatica?	LT___ RT___
Buttocks/Hip?	LT___ RT___	5. Buttocks/Hip?	LT___ RT___
Knees?	LT___ RT___	6. Knees?	LT___ RT___
Ankles?	LT___ RT___	7. Ankles?	LT___ RT___
Feet?	LT___ RT___	8. Feet?	LT___ RT___

2. Have you had surgery to…

Arms & Hands

1. Do you suffer pain in the…

Shoulder?	LT___ RT___	Shoulder?	LT___ RT___
Elbow?	LT___ RT___	Elbow?	LT___ RT___
Arm?	LT___ RT___	Arm?	LT___ RT___
Hands?	LT___ RT___	Hands?	LT___ RT___

2. Have you had surgery to …

Do you have any special concerns or are there any details related to the information above?

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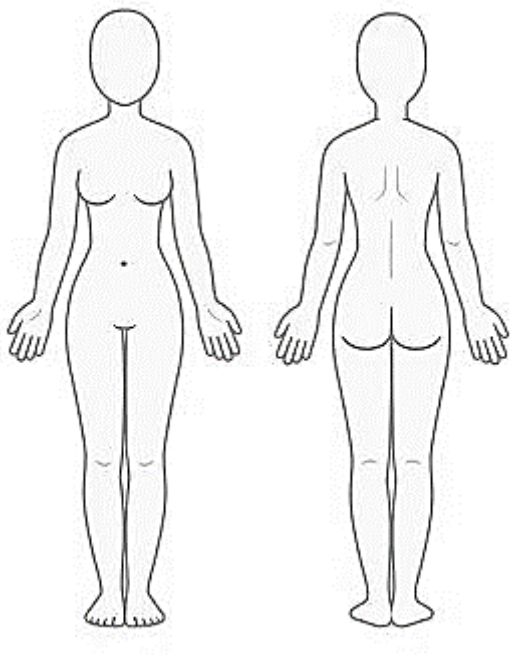
Mark Areas of Pain to indicate location of pain, surgery, or injury:



Areas of Pain

Do you have any special concerns or are there any details related to the information above? Please provide dates and specific details related to surgeries or treatments.

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Client Contract and Treatment Consent Form

Thermography is a non-contact, private, and non-invasive procedure. The value of thermography as a study tool is its ability to measure skin temperature changes suggesting inflammatory response to injury or metabolic effects of tissue disturbance. **It offers men and women supportive information that no other procedure can provide regarding general health. Breast thermography is not a replacement for or alternative to mammography or any other form of breast imaging.** Breast thermography, mammography, or breast ultrasounds are complementary procedures: one test does not replace the other. Breast thermography is meant to be used in addition to other tests or procedures.

This information does not in any way suggest diagnosis and/or treatment. Studies show that the patient benefits when multiple tests are used in combination. This multimodal approach includes breast self-examinations, physical breast exams by a licensed healthcare provider, mammography, ultrasound, MRI, and other tests that may be ordered by your doctor. ***A reported "elevated level of concern" finding does not indicate that is suspicious for any specific disease.*** However, any suspicious finding will be accompanied by a strong and intentional recommendation for further clinical evaluation. If you detect a lump or any other change in your breast before your next thermography study, consult your doctor immediately.

Notice to clients presenting with previously diagnosed conditions including cancer: Thermography interpretation in your report **does not include information or recommendations related to the measured changes of disease beyond skin temperature changes and patterns.** As there is no single known test capable of monitoring all biological influences of the complex diseases, **continued monitoring with available additional testing as recommended by your personal physician is strongly advised.**

Your thermographer may not be a licensed medical professional. **Your thermographer cannot interpret your images or advise or prescribe to you based on your images.** Your thermographer can ask health history questions, as well as educate you on general breast health.

By signing below, I certify that I have read and understand the statement above and consent to the examination. I am not an undercover agent or acting on behalf of law enforcement.

Client Signature _____Today's Date _____