For Office Use Only: Amount_____/Code____/Pmnt Type_____ Tech _____ Reviewer_____ Amount_____

Confidential Patient Information For Your Yearly Functional Physical Exam

PLEASE PRINT

How did you hear about us? Natural Awakenings Networking Group Social Media Website Health Event

If answered Networking Group or Health Event please tell us which group or event._____

Did your Doctor refer you? Y / N If NO, who can we thank for your referral?_____

What 2 experiences do you wish to have during your visit with us?

_____

_____

_____

Are You a Patient of Dr.Michael, Marta Cordell, or Michelle Ewer? Y / N If YES, which one?_____

Personal Information

Name:_____ Home Phone:(_____)_____

Address:_____ Cell Phone:(_____)_____

City:_____ State:_____ Zip:_____ Gender: Female____ Male ____

email:_____ Birthdate ____/____/_____
Month Day Year

Place of Birth_____

Blood Type_____ Left or Right Hand Dominant? _____

May we add you to our email newsletter & special offers? Y / N

Are you interested in receiving our monthly newsletter with specials? Y / N

In Case of Emergency, Notify:_____ Phone:(_____)_____

Relationship to you:_____

Have you had a thermogram before? Y/N If yes, Approximate Date:_____

Location:_____

Height:_____ft_____in Weight: _____

Have you ever Smoked: Y / N If YES, then what and for how long?_____

Family History:

Do you have Children? Y / N If YES, then how many children do you have?_____

What are the Ages of each child? First_____ Second____ Third_____ Fourth_____ Fifth____ Sixth____

Have they been Vaccinated? Y / N

Do your children have any health symptoms or conditions? (e.g. ADD or Allergies or Asthma)

_____

_____

_____

Do you or anyone in your family have a history of any of the following? (This includes grandparents, parents, siblings, cousins and children.) Please circle and indicate who:

☐ Cancer	☐ Glaucoma	☐ Hives
☐ Diabetes	☐ Tuberculosis	☐ Autoimmune disease
☐ Heart disease	☐ Stroke	☐ Thyroid Problems
☐ High Blood Pressure	☐ Anemia	☐ Overweight
☐ Kidney disease	☐ Declining Mental/ Cognitive Function	☐ Acne
☐ Dementia		☐ Alzheimer

☐ Epilepsy ☐ Asthma ☐ Parkinsons
☐ Arthritis ☐ Hayfever ☐ Skin Problems / Rashes / Growths / Warts

Any other relevant family history?_____

_____

Reasons/Symptoms that motivated you to come in today:

_____

_____

_____

Have you experienced ANY of the following? Please **rank** your **TOP 5** concerns (1 being most concerning and 5 being least concerning)

__ Acne
__ Asthma
__ Blackouts
__ Blood Pressure High
__ Blood Pressure Low
__ Fatigue
__ Digestive Problems
__ Eczema
__ Fainting
__ Headaches
__ Hearing Problems
__ Hives
__ Joint Pain
__ Low Back Pain
__ Migraines
__ Palpitations
__ Shortness of Breath
__ Sore Muscles
__ Urination Problems
__ Vision Problems
__ Yeast Infections
__ Overweight

Other Concerns Not Listed: _____

_____

The Following Have Been Removed: Appendix: Y / N Gall Bladder: Y / N Tonsils: Y / N

List Other Hospitalizations, Implants or Surgery (child births, C-section): _____

_____

_____

Do you wake up in the middle of the night to urinate? Y / N If YES, how often_____

Have you ever had a Urinary Tract Infection? Y / N If YES, how often_____

Is it painful to urinate? Y / N

Have you ever had any motor vehicle or other accidents? Y / N

Have you had any emotional upsets or traumas in your life “recently”? Y / N

If Yes, can you please share what happened and the emotion it evokes?

_____

_____

_____

Have you received: Chemotherapy Y / N Date: _____ Radiation Therapy Y / N Date:_____

If YES on either question, then what condition did you receive it for?_____

Dental Work:

Have you had any dental work in the past 3 weeks (including cleanings)? Y / N

Do you have: Caps/Crowns Y/N Dentures Y/N Implants Y/N Root Canal Y / N Other _____

Have you ever had any mercury/gold fillings? Y/N Fillings were removed: Y / N If Yes, then when_____

Do you have your wisdom teeth? Y / N Were your wisdom teeth removed? Y / N

What kind of toothpaste do you use?_____

Do you use a tongue cleaner? Y / N

Do you floss? Y / N

IN THE LAST 24 HOURS, HAVE YOU?

Consumed Alcohol? Y / N If "Y", what & how much?_____

Smoked or Taken Recreational Drugs? Y / N If "Y", what? _____

Did you have any caffeine this morning? Y / N If "Y", when and how much? _____

Did you get a good night's sleep? Y / N

Water:

Do you drink tap water at home? Y / N Do you drink tap water from restaurants? Y / N

Do you drink tap water at work? Y / N

Do you shower in unpurified city water? Y / N Do you drink refrigerator filtered water Y / N

Do you drink well water? Y / N

FEMALES ONLY:

Age of first menses? _____
Length of Cycle? _____
☐ PMS
☐ Hormone replacement therapy
☐ Heavy or excessive flow
☐ Nipple discharges
☐ **Hysterectomy**
☐ Uterine fibroids
☐ Vaginal itching
☐ Painful intercourse
☐ Abnormal PAPS
Number of pregnancies? _____
Number of C-Sections?_____
Ages of your children:_____
☐ Birth control pills

☐ Vaginal dryness
What day of your cycle are you in?_____
☐ **Cycles are regular**
☐ **Cycles are Irregular If so, how irregular**_____
☐ Bleeding between cycles
Age of last Menses (if menopausal)?_____
☐ Ovarian cysts
☐ Vaginal infections/discharge
☐ Swelling or lumps in breast
☐ Difficulty conceiving
☐ Endometriosis
Number of live births? _____
New moms: currently nursing your child? Y/N
Number of miscarriages? _____
☐ Sexual difficulties
☐ Infertility

MALES ONLY:

☐ Hernias
☐ Lumps, swelling, masses in testicles
☐ Discharge or sores
☐ Painful erections
☐ Hormone replacement therapy

☐ Testicular pain
☐ Prostate disease
☐ Difficult or loss of erection
☐ Infertility
☐ Vasectomy

I understand that CRT Thermography is not a primary diagnostic device as deemed by the U.S. Food and Drug Administration and is not to exclude other methodologies of cancer detection. Its purpose is to add information to the physician or practitioner to aid in the integration of other tests and results in order to achieve treatment outcomes, and not intended as diagnostic of any disease or dysfunction in itself. I agree to not hold the Thermography Report Writing Services responsible for any decision I or my doctor make based on the results obtained. I am ultimately responsible for payment to the Thermography Center and accept that the Center does not bill insurance companies. Payment is due at the time of service. You will be given a receipt for your visit, which you can submit to your insurance company for reimbursement. If the insurance company does not pay for the services, The Thermography Center assumes no responsibility for reimbursement.

_____ _____
Signature Date

THE THERMOGRAPHY Center, L.L.C.

Telephone (214) 352-8758
email: thermography@thermographycenter.com

5220 Spring Valley Rd #405
Dallas, TX 75254

The Thermography Center
("The Center")
Patient Consent for Diagnostic Screening with Alfa Sight 9000

I have requested and do hereby authorize The Thermography Center ("The Center") or any qualified and certified agents, independent contractors, or trainees of the Computerized Regulation Thermography (Alfa Sight 9000) System to perform adjunctive diagnostic screening test with the Alfa Sight 9000 for the sole purpose of information only. I understand that The Center is not a medical facility and will not be treating me or diagnosing any medical condition. I understand that the test data or readings from this procedure will be classified and categorized by an independent party familiar with the Alfa Sight 9000 and the data will be forwarded to my chosen medical professional for interpretation and medical care intervention. **Regulation Thermography is an adjunctive NOT primary diagnostic tool**. **I am responsible for following up with medical care with my physician and should not rely on this procedure for the diagnosis or treatment of any medical condition**. I further understand The Center operates as a separate business from Dr. Theodore J. Tuinstra.

I certify that I have consulted with a representative of The Center and have read all applicable literature given to me. I have read and fully understand all of the information presented in this Patient Consent and Release form for Diagnostic Screening. I accept the explanation of my responsibility for following up with a medical care professional of my choosing and understand that the diagnostic screening test data will not be mailed to me but directly to my medical professional I designate on my intake forms. I certify that I am eighteen (18) years of age or older, of sound mind, and I am fully capable of executing this Patient Consent and Release form for Diagnostic Screening myself.

Name: _____

Date of Birth: _____

Signature: _____ Date: _____