**Living Springs Natural Health (LSNH) & Living Springs Health & Wellness (LSHW), PLLC are members under the:**



TURTLE ISLAND PROVIDER NETWORK Licensed & Registered by: Tribal Health Programs & Clinics

A Private Tribal Membership Facility **NOT OPEN TO THE PUBLIC**

**THERMOGRAPHY – MEN’S HEALTH SCREENING**

|  |
| --- |
| Name: Type Name: Last, First Middle Date: Select Today’s Date |
| Date of Birth: Select D.O.B. Age Age: Gender: Gender Occupation: Occupation |
| Home Address: Enter Street Address City: Enter City State: Enter State Zip: Enter Zip |
| Email Address: Enter Email Address |
| Home Phone: Enter Home Phone # Cell Phone: Enter Cell Phone # Work: Enter Work Phone # |
| In Case of Emergency Contact: Emergency Contact Relationship: Relationship Phone: Enter Phone # |
| How did you hear about Us: Enter Text |
| Please list all the providers you are seeing and/or referring physician: List Providers |
| Is there a specific reason or concern for this exam? Enter Text |

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

**Head & Neck**

1. Do you suffer from headaches? **Yes** **No**

If yes:  once a month or less more than once a month

1. Do you have known allergies?     
   If yes:  Food  Environmental
2. Do you have TMJ or does your jaw click?
3. Do you currently have a cold?
4. Are you being treated for a thyroid disorder?    
   If yes: What Type? Enter Text
5. Do you have neck pain?
6. Do you have upper back pain?
7. Do you have a known history of carotid artery disease?
8. Do you have a family history of stroke?
9. Do you currently suffer with sinus problems?
10. Do you have history of dental problems?    
    If yes:  Root canals  Gum disease  Implants

Non-replaced extractions  Dentures

1. Have you had dental cleaning in the past 7 days?

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

**CHEST, HEART & LUNGS**

1. Have you been diagnosed with: **Yes** **No**

Heart disease?

Lung disease?

Upper spine disorders?

2. Do you suffer with upper back pain?

3. Do you suffer with chest pain?

4. Have you ever had surgery to your:

Heart?

Lungs?

Mid to upper back?

5. Do you have asthma or shortness of breath?     
6. Do you currently smoke?     
7. Have you smoked in the past 5 years?

**ABDOMEN & LOWER BACK**

**Yes** **No**

1. Do you suffer with acid reflux or any other digestive problems?
2. Have you had surgery or disease in the: (Select ALL that apply)

Stomach  Below R Breast  Below L Breast  
 Abdomen  Lower Back  Pelvic Region

1. Do you suffer pain in the: (Select ALL that apply)  
    Stomach  Kidneys  Intestines Abdomen  
    Pelvic Region  Lower Back  Spleen (Upper Left)  Liver (Upper Right)
2. Have you consumed alcohol in the past 24 hours?

Do you have any special concerns or any additional details related to the information above?  
Enter Text

***Procedure:*** *You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.*

***Patient Disclosure:*** *I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, but will be an analysis of the images with respect only to the thermographic findings discussed in the report.*

*By signing below, I certify that I have read and understand the statement above and consent to the examination.*

\*\*\* Please Note: We do not file with insurance at this office & will not provide codes. The alternative therapies/suggestions we provide are not intended to diagnose, treat, cure or prevent any disease \*\*\*

**I understand, agree & provide my consent that the submission of this form electronically requires the use of a digital signature. By signing, I agree that my digital signature on this form has the same legal affect as my manual signature (in accordance with the ESIGN Act).**

**Date:** Click to Select a Date.

**E-SIGN Your Name Here** Patient Signature