



# Thermography Center of Memphis

## Client Intake Form

Name \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

State, Zip \_\_\_\_\_

Occupation \_\_\_\_\_

E-mail \_\_\_\_\_

Phone (please include area code) (H) \_\_\_\_\_ (W) \_\_\_\_\_

(C) \_\_\_\_\_ Leave message w/results? Yes / No

Reason for today's visit: \_\_\_\_\_

\_\_\_\_\_

Current Symptoms: \_\_\_\_\_

\_\_\_\_\_

Current Treatment: \_\_\_\_\_

\_\_\_\_\_

Previous illnesses: \_\_\_\_\_

\_\_\_\_\_

Previous Surgeries/Dates: \_\_\_\_\_

Injuries/Dates: \_\_\_\_\_

Current Medication(s): \_\_\_\_\_

Do you want your report sent to your Health Care Provider? (circle one) Yes No

Provider's name and address: (each additional \$10) \_\_\_\_\_

\_\_\_\_\_

This information is confidential. All information is correct to my knowledge.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### For office use only:

Patient ID# \_\_\_\_\_ Next Appt. \_\_\_\_\_

Report Ref # \_\_\_\_\_ BR1 BR2 BRA HB FB

ROI \_\_\_\_\_

Referred by \_\_\_\_\_

Scans uploaded \_\_\_\_\_

Data updated \_\_\_\_\_ Pt called \_\_\_\_\_

SOC \_\_\_\_\_ PT rpt sent \_\_\_\_\_ CD HCP rpt sent \_\_\_\_\_ PR

Pymt \_\_\_\_\_ Ck # \_\_\_\_\_ Cash \_\_\_\_\_ V MC D AMX