Thermography Center of Memphis

Client Intake Form

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

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: _____

This document is confidential and legally privileged. Any retention, dissemination, distribution or copying of this communication is strictly prohibited.