

THERMOGRAPHY CLINIC INC.

143 SHEPPARD AVENUE WEST
TORONTO ON. M2N 1M7

Full Body & Pain History

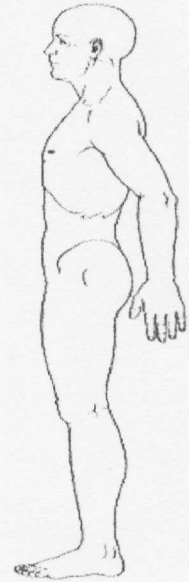
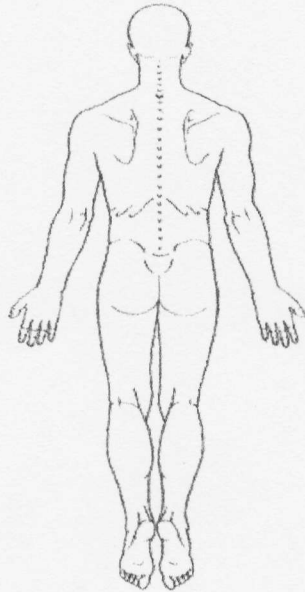
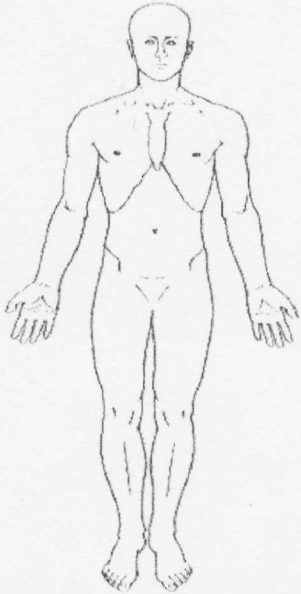
Date: _____ Date of Birth: _____

Name: _____ Street: _____

City: _____ Province: _____ Postal Code: _____

Tel. (Res.) _____ Tel (Bus.) _____ Email: _____

Mark the location of symptoms with an "X" and label it as sharp, dull, burning, aching, etc.



Please Note Level of Pain

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10
Mild: Annoyance **Moderate: Some Limitations** **Severe: Pain Killers Needed**

Describe your symptoms: _____

How and when did this start? _____

Were you examined for this complaint? _____ Date and Results: _____

What increases your symptoms? _____