# Cranial History

Name:_____ Sex:____ Age:_____ Date:_____

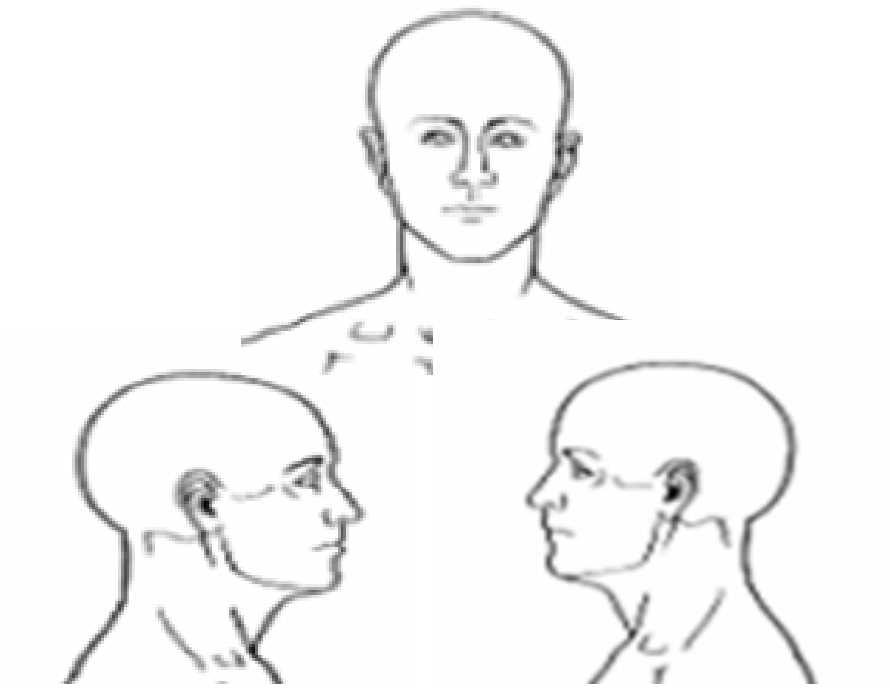
Address:_____

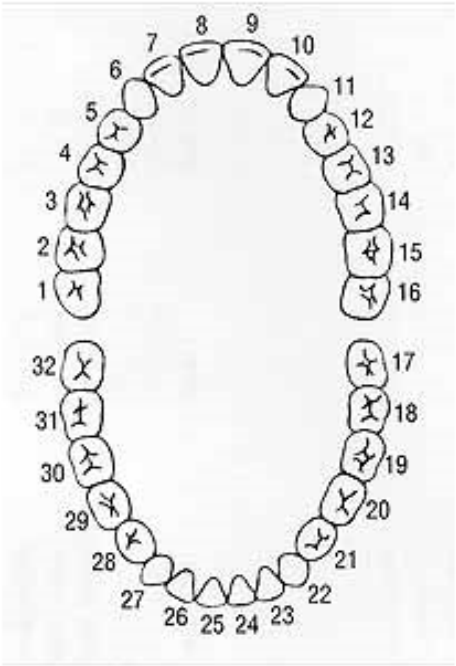
City:_____ State:_____ Zip:_____

Phone #:_____ Referred by:_____

How did you hear about us? ❒ Internet ❒ Person Other _____

**Please mark the region of your concern on the diagrams below.**






Please describe any specific concerns:

❒ Dental _____

❒ Sinuses _____

❒ Facial Pain or Numbing _____

❒ Thyroid Concerns_____

❒ Lumps in Neck_____

❒ Dizziness or Lightheadedness_____

❒ Other _____

Do you have any history of:

❒ Stroke ❒ Cardiovascular Disease ❒ Dizziness ❒ Fainting

Please Describe: _____

❒ Past Injuries to the face

Please Describe: _____

Do you have any diagnosed diseases?

Please Describe: _____

Do you have any past surgeries to the head, face or mouth?

Please Describe: _____

# Release for Testing Procedure

Thermal Imaging provides physiological and functional diagnostic information and does not replace any other diagnostic procedure.

I have read the above information and understand that I am not receiving a diagnosis based on my thermal scan. I authorize this clinic's personnel to perform this and all subsequent thermal imaging examinations.

I have complied with the pre-examination instructions for proper thermal imaging.

**Name: _____ Signature: _____ Date: _____**

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**Please do not write in this section**

· Initial Exam · Re-Exam Tech: _____

Patient Temperature: _____ F Laboratory Temperature: _____ C

Additional Information: