



TRUE ADVANTAGE
IMAGING LLC

Confidential Questionnaire

Upper Body Pain Study

Name _____ Birth Date _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Phone Number (home) _____ (cellular) _____ (work) _____

E-Mail Address _____ Referring Physician _____

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermographer and any other practitioner that you specify. This is a specific pain study, so questions related to other conditions are grayed out. If a more comprehensive health study is desired, choose a Health Study instead.

Yes No

Head & Neck Related Pain

- | | | |
|--|-------|-------|
| 1. Do you suffer with headaches?
If yes, once a month or less _____ more than once a month _____ | _____ | _____ |
| 2. Do you have known allergies? Food _____ Environmental _____ | _____ | _____ |
| 3. Do you have TMJ or does your jaw click? | _____ | _____ |
| 4. Do you currently have a cold? | _____ | _____ |
| 5. Are you being treated for a thyroid disorder? Type _____ | _____ | _____ |
| 6. Do you have neck pain? | _____ | _____ |
| 7. Do you have upper back pain? | _____ | _____ |
| 8. Do you have a known history of carotid artery disease? | _____ | _____ |
| 9. Do you have a family history of stroke? | _____ | _____ |
| 10. Do you currently suffer with sinus problems? | _____ | _____ |
| 11. Do you have history of dental problems?
Root canals _____ Gum disease _____ Implants _____
Non-replaced extractions _____ Dentures _____ | _____ | _____ |
| 12. Have you had dental cleaning in the past 7 days? | _____ | _____ |
| 13. Have you been diagnosed with elevated cholesterol | _____ | _____ |

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

Chest, Shoulder and Upper Back Related Pain

- | | Yes | No |
|---|------------|-----------|
| 1. Have you been diagnosed with: | | |
| 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 been diagnosed with scoliosis? | ___ | ___ |
| 5. Have you ever had surgery to your: | | |
| Heart? | ___ | ___ |
| Lungs? | ___ | ___ |
| Mid to upper back? | ___ | ___ |
| 6. Do you have asthma or shortness of breath? | ___ | ___ |
| 7. Do you currently smoke? | ___ | ___ |
| 8. Have you smoked in the past 5 years? | ___ | ___ |
| 9. Do you suffer with shoulder pain? If yes; mark below | ___ | ___ |

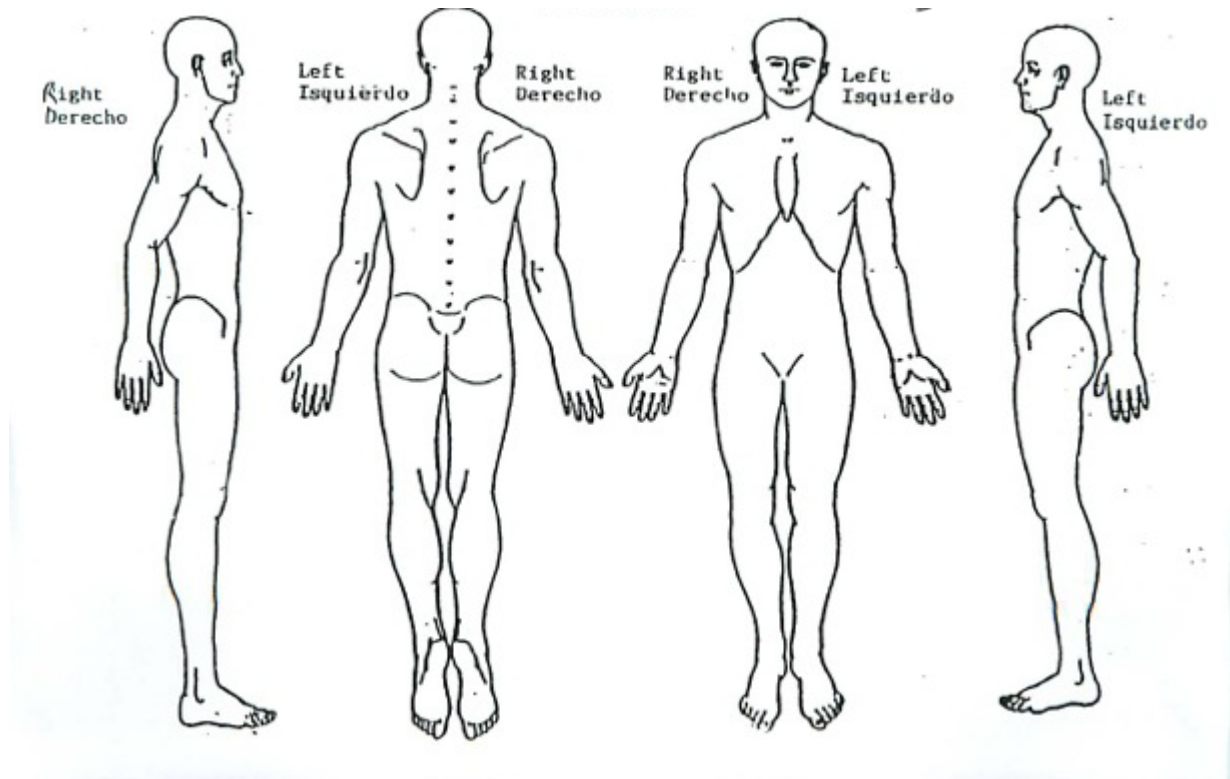
Do you have any special concerns or are there any details related to the information above?

Upper Extremities Related Pain

Check only if "Yes"

- | | | | | | |
|---|-----------|-----------|------------------------------------|-----------|-----------|
| 1. Do you suffer with pain in the: | LT | RT | 2. Have you had surgery to: | LT | RT |
| Shoulder? | ___ | ___ | Shoulder? | ___ | ___ |
| Elbow? | ___ | ___ | Elbow? | ___ | ___ |
| Arm? | ___ | ___ | Arm? | ___ | ___ |
| Hands? | ___ | ___ | Hands? | ___ | ___ |

Mark Areas of Pain with Description (burning, stabling, aching) and duration (chronic = more than 6 months)



Areas of Pain

Do you have any additional information or special concerns related to the information above?
Please provide dates and specific details related to surgeries or treatments.

Client Disclosure

Thermography is a non-contact, private and non-invasive procedure. The value of thermography as a study tool is its ability to measure skin temperature changes suggesting inflammatory response to injury or metabolic effects of tissue disturbance. **It offers men and women supportive information that no other procedure can provide regarding general health.**

This information **does not in any way suggest diagnosis and/or treatment.** Studies show that the patient benefits when multiple tests are used in combination. This multimodal approach includes physical exams by a licensed healthcare provider, ultrasound, MRI and other tests that may be ordered by your doctor.

Notice to clients presenting with previously diagnosed conditions including cancer: Thermography interpretation in your report **does not include information or recommendations related to the measured changes of disease beyond skin temperature changes and patterns.** As there is no single known test capable of monitoring all biological influences of the complex diseases, **continued monitoring with available additional testing as recommended by your personal physician is strongly advised.**

Your Thermographer may not be a licensed medical professional. **Your Thermographer cannot interpret your images or advise or prescribe to you based on your images.** Your thermographer can ask health history questions as well as educate you on general breast health.

By Signing below, I certify that I have read and understand the statement above and consent to the examination. I am not an undercover agent or acting on behalf of law enforcement.

Client Signature _____ Today's Date _____