THERMOGRAPHY CLINIC INC.

143 SHEPPARD AVENUE WEST
TORONTO ON. M2N 1M7

Full Body & Pain History

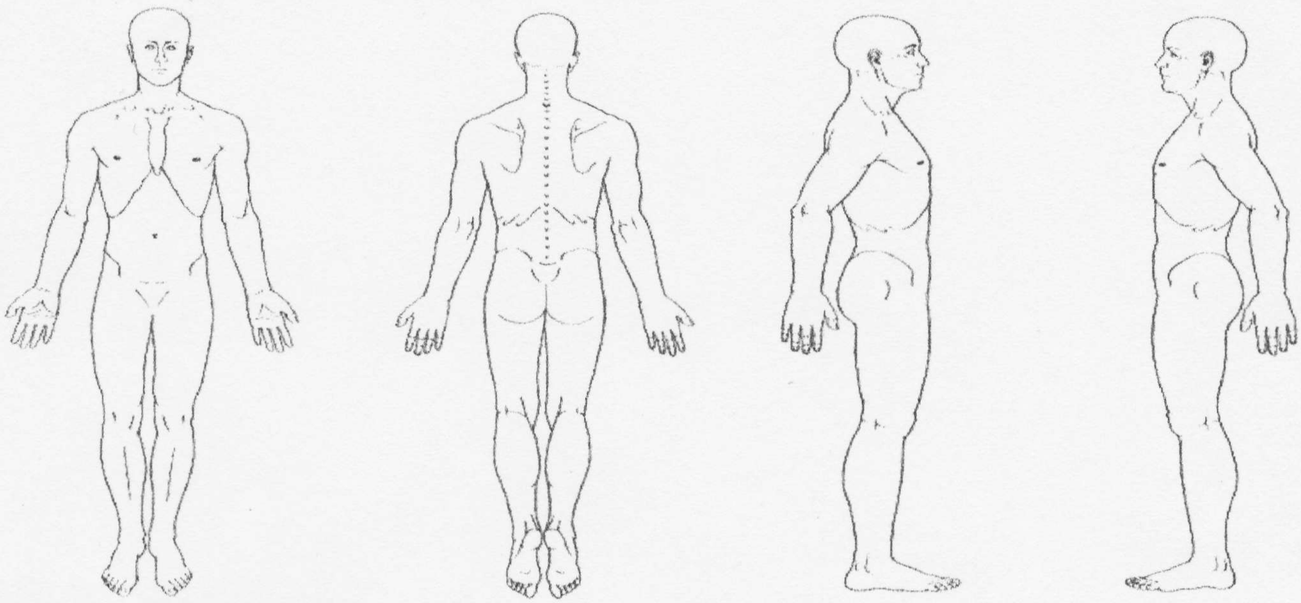
Date: ______________________________ Date of Birth: ___________________________________

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: ____

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How and when did this start? ____

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Were you examined for this complaint? ___________ Date and Results: ______________________

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What increases your symptoms? ____