Lower 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.***

Lower Back Related Pain

Check only if "Yes."

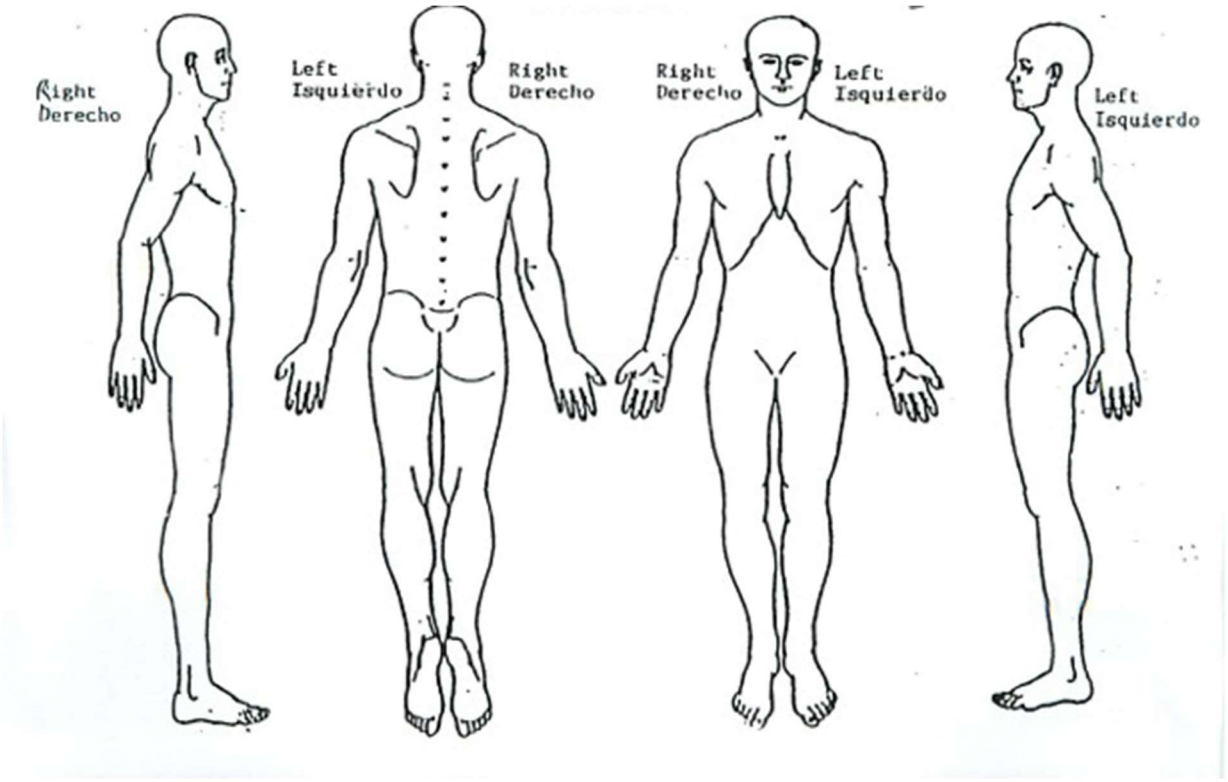
1. Do you suffer with acid reflux or other digestive problems? Yes No	3. Have you had surgery to these areas? Provide more details below:
2. Do you suffer pain in the:	Stomach? Yes___ No___
Stomach? Yes___ No___	Spleen (Upper Left) ? Yes___ No___
R Rib Area? Yes___ No___	Liver (Upper Right) ? Yes___ No___
L Rib Area? Yes___ No___	Kidneys? Yes___ No___
Abdomen? Yes No	Intestines? Yes No
Lower Back? Yes No	Abdomen? Yes No
Pelvic Region? Yes___ No___	Lower Back? Yes___ No___
	Pelvic Region? Yes___ No___

Lower Extremities Related Pain

Check only if "Yes."

1. Do you suffer pain in the:	2. Have you had Surgery to:
Leg? LT___ RT___	Leg? LT___ RT___
Sciatica LT___ RT ___	Sciatica? LT___ RT ___
Buttocks/Hip? LT___ RT___	Buttocks/Hip? LT___ RT___
Knees? LT___ RT ___	Knees? LT___ RT ___
Ankles? LT___ RT ___	Ankles? LT___ RT ___
Feet? LT___ RT ___	Feet? LT___ RT ___

Mark any Areas of Pain with Description (burning, stabling, aching)



Description:
