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.***

Head & Neck Related Pain

1. Do you suffer with headaches?

If yes, once a month or less____ More than once a month____ No____

2. Do you have any known allergies?

If yes, food____ Environmental_____ No____

3. Do you have TMJ or does your jaw click?

Yes____ No____

4. Do you currently have a cold?

Yes____ No____

5. Are you being treated for a thyroid disorder?

If yes, what type? _____ No____

6. Do you have neck pain?

Yes____ No____

7. Do you have upper back pain?

Yes____ No____

8. Do you have a known history of carotid artery disease?
Yes____ No____

9. Do you have a family history of stroke?
Yes____ No____

10. Do you currently suffer with sinus problems?
Yes____ No____

11. Do you have a history of dental problems?

If yes, Root canals ____ Gum disease ____ Implants ____ Non-replaced extractions ____

Dentures ____ No____

12. Have you had dental cleaning in the past 7 days?
Yes____ No____

13. Have you been diagnosed with elevated cholesterol?
Yes____ No____

Chest, Shoulder, and Upper Back Related Pain

1. Have you ever been diagnosed with:
Heart disease ____ Lung disease ____ Upper spine disorders____ No___

2. Do you suffer with upper back pain?
Yes____ No____

3. Do you suffer with chest pain?
Yes____ No____

4. Have you ever been diagnosed with scoliosis?
Yes____ No____

5. Have you ever had surgery to your:

Heart____ Lungs____ Mid to upper back____ No___

6. Do you have asthma or shortness of breath?

Yes____ No____

7. Do you currently smoke?

Yes____ No____

8. Have you ever smoked?

If yes, for how long_____ Packs/Day____ No___

9. Do you suffer with shoulder pain?

If yes, Left____ Right____ No____

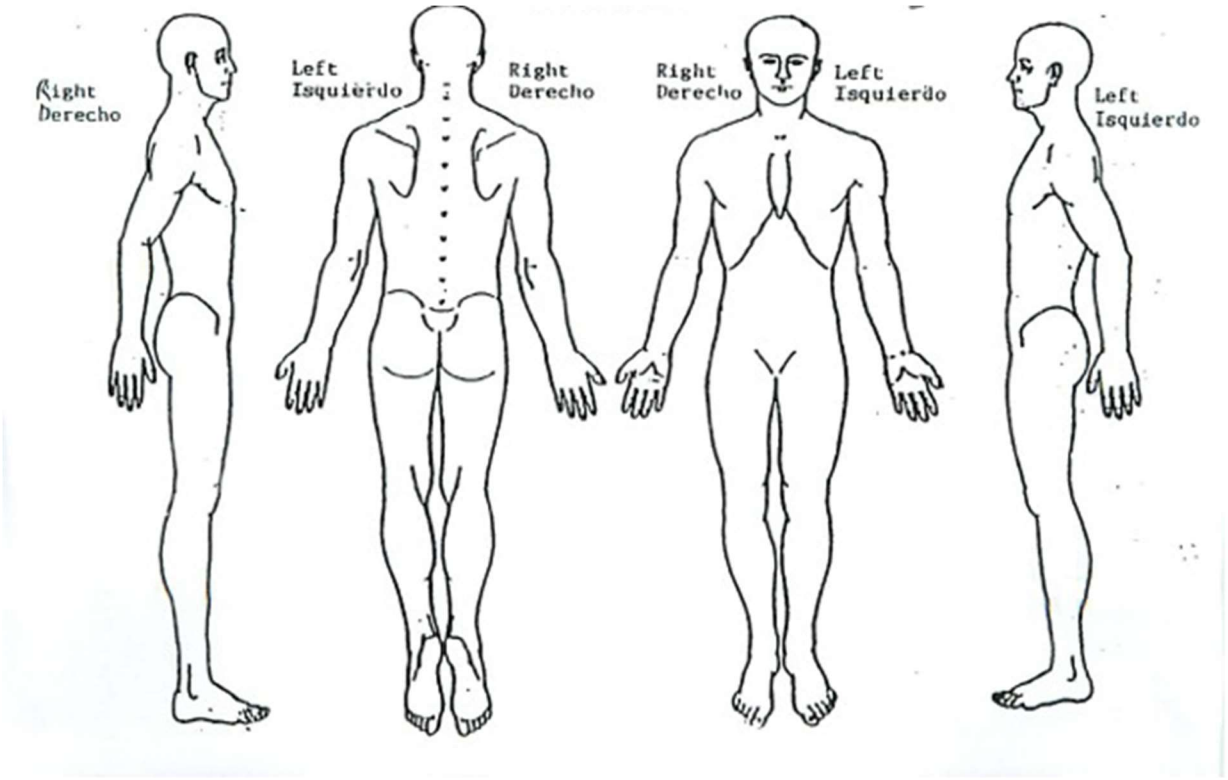
Upper Extremities Related Pain

Check only if "Yes."

1. Do you suffer with pain in the:	**LT**	**RT**
Shoulder	____	____
Elbow	____	____
Arm	____	____
Hands	____	____

2. Have you had surgery to:	**LT**	**RT**
Shoulder	___	___
Elbow	____	____
Arm	___	___
Hands	___	___

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



Description