The Thermography Center
A Division of Radiant Health, Inc.

Client Information:

Name: _____ D.O.B _____

Address: _____

Phone: (H) _____ (Cell) _____

Occupation: _____ Email: _____

Previous Illnesses:

Previous Surgery:

Current health problems or concerns:

Scar Tissue:

Medication:

Vitamins/Herbs:

Other Treatment:

Current Doctor:

Please choose ***only one*** of the following ways to receive your report**:**
We prefer to email your report and images. Is this ok with you? _____ ***or***

Do you prefer for your report to be sent to you by mail for a fee of $5.00 for breast or region of interest and $10 for full body screening? _____

Please share with us how you heard about our services:

This information is confidential. All information is correct to my knowledge.

Signed _____ Date _____