The Thermography Center

A Division Radiant Health Thermography, Inc.

Client Information:

Name: _____ D.O.B _____

Address: _____

Phone: (H) _____ (Cell) _____

Occupation: _____ Email: _____

Medical History/Previous Illness:

Previous Surgery (including Dental):

Current health problems or concerns:

Scar Tissue/Skin Abnormalities:

Medication, Vitamins/Herbs:

Family History:

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. Our website and address are below.

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

Signed _____ Date _____

115 Pirie Road, Suite B
Ojai, CA 93023
805-560-7602 Or 310-871-5647
www.TheThermographyCenter.com