



Thermography Centers
A Division of Radiant Health, Inc.

Client Information:

Name: _____ D.O.B _____

Address: _____

Phone: (H) _____ (Cell) _____

Occupation: _____ Email: _____

Current health problems or concerns:

Previous Illnesses:

Previous Surgery:

Scar Tissue:

Medication:

Vitamins/Herbs:

Other Treatment:

Current Doctor:

Vaccination or Booster within the past 2 weeks:

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 _____

115 Pirie Road, Suite B
Ojai, CA 93023
805.560.7602
www.TheThermographyCenter.com