



FOR OFFICE USE ONLY

Pt ID #: _____ Rpt #: _____

HB FB ROI - URGENT - INV

EM-C (PW: text / call) - M-C / M-D - LOC: _____

Returning Patient Information Sheet

Name _____ Date _____

Has your contact information changed since we saw you last? Y N If so, provide below.

Address _____ Cell Phone _____

City, State, Zip _____ Alt Phone _____

Occupation _____ Age _____

Email Address _____

Current Health Concerns _____

Troublesome Symptoms _____

What Aggravates/Relieves Them _____

Any Treatment for This Condition _____

Current Doctor and Type _____

Medications (including prescribed, hormones, and over the counter) _____

Any Major Illness Since Last Scan _____

Any Surgery Since Last Scan _____

Anything else you think is important for us to know? _____

Have you had a vaccine in the past 4 weeks? Yes* No

*If yes, date: _____ Which arm? Right Left

How would you like to receive your report? Email to Me Mail to Me Send to My Doctor*

**If sending to your doctor, please provide the following:*

Doctor's Name _____ Doctor's Phone # _____

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

Signed _____ Date _____

Printed Name _____

UPPER BODY QUESTIONNAIRE

Please chose Y for Yes and N for No on the following questions:

HEAD & NECK

- Y N Do you suffer with headaches? If yes, how often? _____
- Y N Do you have allergies? If yes, to what? _____
- Y N Do you have: TMJ OR Jaw clicks when chewing
- Y N Do you currently have a cold?
- Y N Are you being treated for a thyroid disorder? If yes, how? _____
- Y N Do you have neck pain? If yes, describe _____
- Y N Do you have a history of carotid artery disease?
- Y N Do you have a family history of stroke?
- Y N Do you currently suffer with sinus problems?
- Y N Do you have any: dental crowns/caps root canals metal amalgams dental implants
If yes, list where these are in your mouth: _____
- Y N Do you have: Gum disease Receding gums Bleeding gums

CHEST

- Y N Have you ever been diagnosed with Heart Disease
If yes, please list diagnosis: _____
- Y N Do you suffer with chest pain? If yes, describe _____
- Y N Have you ever had surgery in the following area: Heart
- Y N Do you have any special concerns or details related to the information given above? If so, please list:

BACK

- Y N Do you have pain in the following areas:
 Upper Back Lower Back
If yes, describe pain(s) _____
- Y N Do you have: Asthma OR Shortness of breath
- Y N Do you currently smoke?
- Y N Have you smoked in the last 5 years?
- Y N Have you ever been diagnosed with: Lung Disease Mid to Upper Spine Disorders
If yes, please list diagnosis: _____
- Y N Have you had surgery or suffered with a condition (infection, etc.) in the following?:
 Lungs Mid to Upper Back Lower Back Kidneys
If yes, list surgery/condition and when _____
- Y N Do you have any special concerns or details related to the information given above? If so, please list:

UPPER BODY QUESTIONNAIRE, Continued...

ABDOMEN

Y N Do you suffer from acid reflux? If yes, how often _____

Y N Do you have pain in the following areas:

Stomach Abdomen (upper/lower) Below Right Breast

If yes, describe pain(s) _____

Y N Do you experience:

Constipation Diarrhea Bloating Indigestion

Y N Have you had surgery or suffered with a condition (infection, etc.) in the following?:

Stomach Spleen (upper left) Liver (upper right) Intestines Abdomen

If yes, list surgery/condition and when: _____

Y N Do you have any special concerns or details related to the information given above? If so, please list:

ARMS & HANDS

Y N Do you have pain in the following? If yes, describe pain(s) _____

Shoulder RT LT Elbow RT LT

Arm RT LT Hands RT LT

Y N Have you had surgery or suffered with a condition (tear, broken bone, etc.) in the following?:

Shoulder RT LT Elbow RT LT

Arm RT LT Hands RT LT

If yes, list surgery/condition and when: _____

Y N Do you have any special concerns or details related to the information given above? If so, please list:
