



**PATIENT ID:**  
**REPORT NO:**  
**DATE:**  
**PRICE OF SCAN: £**

**THERMAL IMAGING  
REGISTRATION**

**PERSONAL DETAILS**

First appointment date: \_\_\_ / \_\_\_ / \_\_\_

Surname:		Forenames:	
Title: Mr /Mrs /Ms /Miss/Other		Date of birth: ___ / ___ / ___	Age:
Address:			
		Postcode:	
Telephone (H):		(Mobile)	
E-mail:			

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Are you a patient of Dr Daya?

In the past  Currently  In the future (*I have made an appointment*)  No

**What is your preferred form of contact for reminders and messages? (please tick)**

By letter  By email  (address) \_\_\_\_\_

\*By landline  \*By mobile  \*Do you give us permission to leave a full message on this number (*stating the clinic name and a brief message on why we are calling you*)?

Yes

No

**PATIENT DISCLOSURE**

*I understand that the report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the report.*

- *I would like a copy of my report to be sent to my referring practitioner. YES/NO*
- *I understand that it is my own responsibility as the patient to choose whether to accept any treatment or test options professionally offered.*

*By signing below, I certify that I have read and understand the statements above and consent to the examination*

Signature \_\_\_\_\_

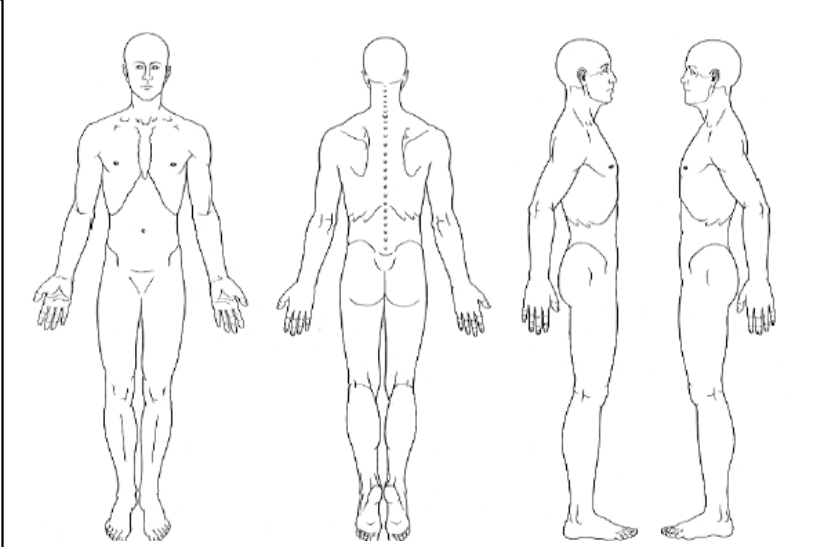
Today's date \_\_\_\_\_

### Region of Interest Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

<b>Name:</b>	<b>D.O.B:</b>
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Please Show areas of :

<p>Main Pain *</p> <p>Secondary Pain ○</p> <p>Numbness //////////////</p> <p>Pins and needles ::::::::::</p> <p>Skin lesions / scaring →</p>	
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Do you know what triggered the pain ?

Does anything relieve it ?

Does anything aggravate it ?

Has it changed since it began ?

Have you had any treatment ?

<p>History: Injuries / Fractures / Surgery</p>          
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*We sometimes use test results from our patients in our research programme and when we do, this is in a completely anonymous way. It helps us make treatment advances in the work we are doing. Do you object to the anonymous use of your tests results for research purposes?*

No, I do not object

Yes, I do object

Signed: \_\_\_\_\_

Date: \_\_\_\_\_