

# TTI Wellness Entry Form

8341 La Mesa Blvd., La Mesa, Ca. 91942 Phone: 619.303.5884

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 E-Mail: \_\_\_\_\_ Home Ph. # \_\_\_\_\_ Cell Ph.# \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Home Ph.# \_\_\_\_\_  
 Receive your report: In person / Mail / E-Mail Last Thermogram: / /

**Breast Questionnaire -**

Occupation: \_\_\_\_\_ I was referred by \_\_\_\_\_

have you had the following:  
 Diagnosed with breast cancer? **Yes / No**  
**If yes: type- Metastatic / Lymphatic node removal / Local** When: / /  
 Diagnosed of other breast disease? **Yes / No**

Biopsies and your findings? **Yes / No**

Breast surgery/ implants? **Yes / No**

Mammogram last 12 months? **Yes / No**

Total mammograms # \_\_\_\_\_

First mammogram # \_\_\_\_\_

Contraceptive over 1 year? **Yes / No**

Hormone therapy? **Yes / No**

Doctors last breast exam? / /

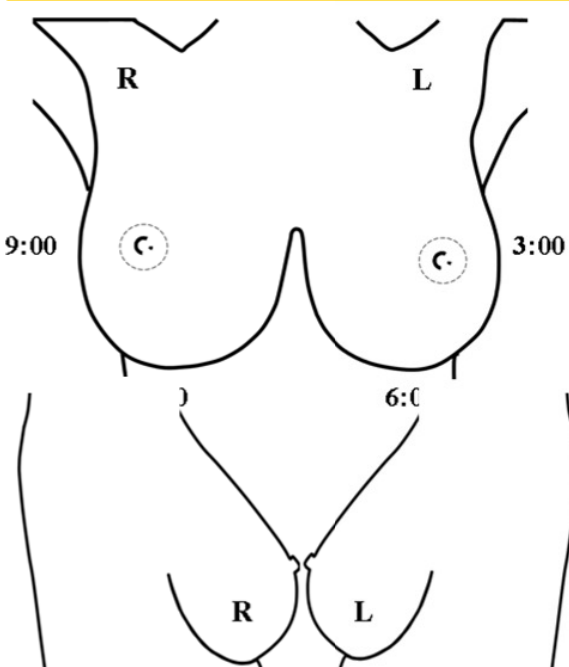
Monthly breast self exams? **Yes / No**

Menstrual periods before 12? **Yes / No**

Menstrual stopped after 50 ? **Yes / No**

Total births #? \_\_\_\_\_, age of first born? \_\_\_\_\_

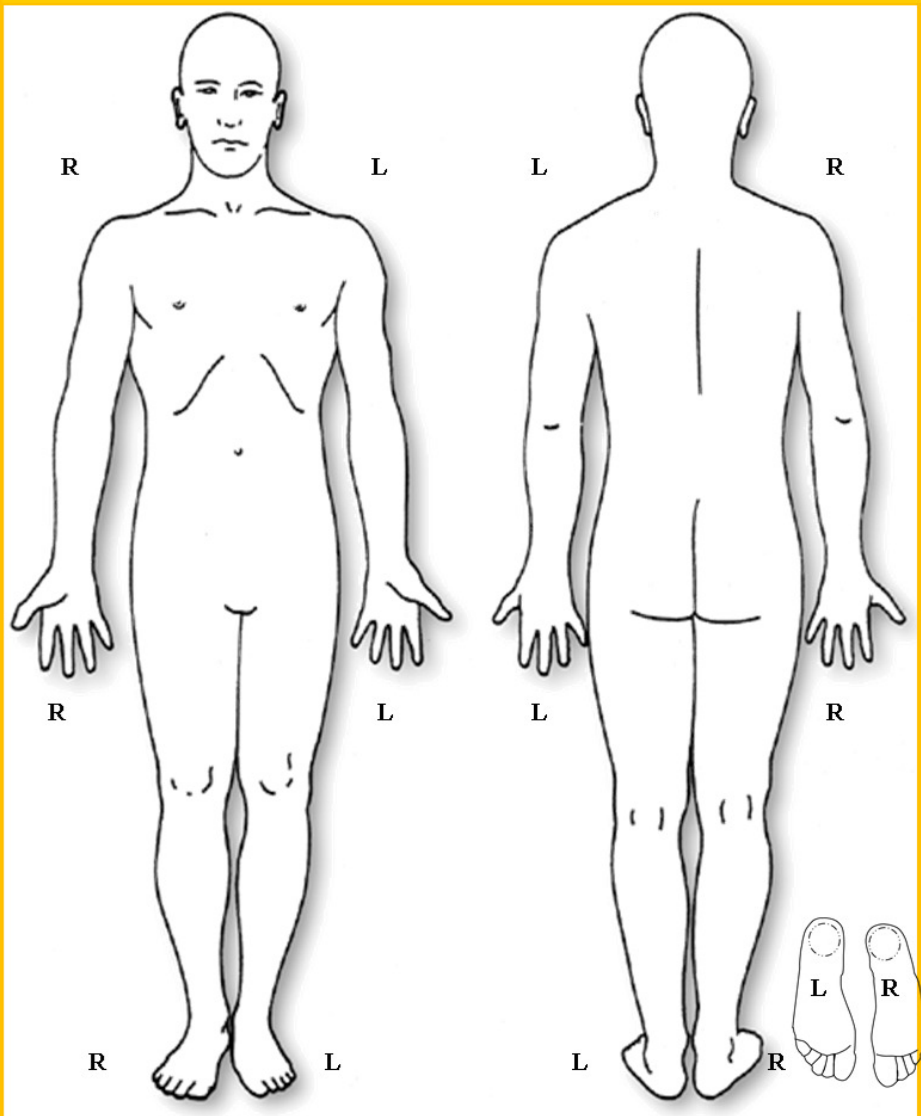
Breast symptoms in the last 6 months?  
 Please demonstrate symptoms with following symbols: "T" for Tenderness; "L" for Lumps; "D/T" for Nipple Dimpling /Thickening. Change in size "CS"; "NS" Nipple secretion, Biopsy "B".



**Patient Disclosure**

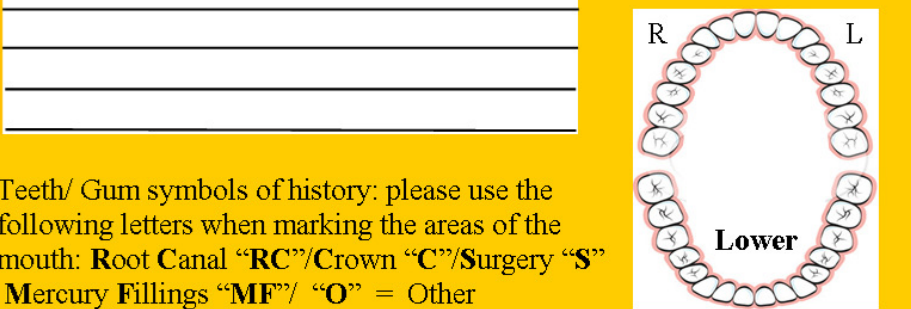
*I understand the report generated by my images is intended for use by trained health care providers to assist in evaluation, analysis and treatment. I understand the report is not intended for use by individuals for self-evaluation, diagnosis, or treatment. I understand the report will not tell me whether I have an illness, disease, or other condition but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the report. By signing below, I acknowledge and certify that I have read and understand the statements above and consent to the examination. I also authorize the release of information and the receipt of information in the pursuit of comprehensive evaluation and treatment relating to the services provided by Thermography Unlimited, LLC/ Total Thermal Imaging.*

Please demonstrate symptoms with the following symbols with accurate locations on the body figure below: "N" for numbness; "1-10" for pain 10 being the worst; "S" for scars; "M" for moles; "F" for fractures; "X" for previous surgeries or current/prior diseases with a line to a brief description.



Current Issues /Accidents? \_\_\_\_\_

Current medications \_\_\_\_\_



Teeth/ Gum symbols of history: please use the following letters when marking the areas of the mouth: Root Canal "RC"/Crown "C"/Surgery "S" Mercury Fillings "MF"/ "O" = Other

**For Office Use Only:** First Visit 3 month 1 YR Recall Super Bill

Description \_\_\_\_\_ Cost \$ \_\_\_\_\_

Payment Method: Check# \_\_\_\_\_ Check / Cash \$ \_\_\_\_\_

Credit Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_  
 Visa MasterCard Discover

Billing Address \_\_\_\_\_  
 SAME AS ABOVE

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature Authorizing Payment