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PAGOSA WELLNESS
SEDONA WELLNESS

390 Boulder Drive, Suite 100
Pagosa Springs, CO 81147
414 Peace Garden Path
Clarkdale, AZ 86324

When was your last thermal: / / I was referred by _____

Name: _____ Birth Date: _____

Mailing Address: _____

E-Mail: _____ Home Ph.#: _____ Cell Ph.#: _____

Emergency Contact: _____ Home Ph.#: _____

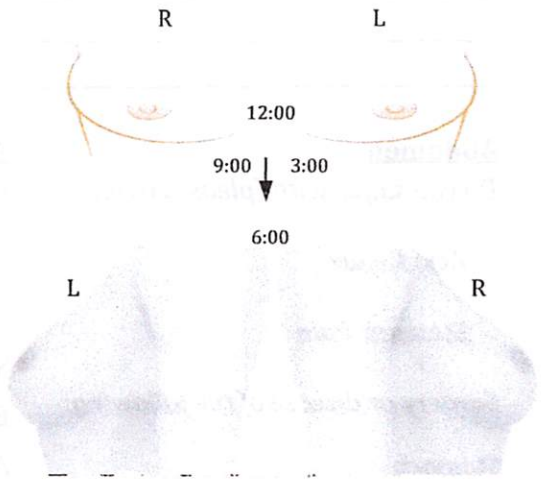
Format you desire to receive your report: In person by appointment / Mail / E-Mail

Breast Questionnaire

Room Temperature: Start ° C F
End ° C F

(Circle Yes/No with Clock positions on positive findings)

1. Do you have any close relative that has breast cancer? Yes No If yes, Relationship: _____
2. Have you ever been diagnosed with breast cancer? Yes No If yes, type: Mestatic / Lymph node / Local
   When:
   Where: Right: Left:
3. Have you ever been diagnosed with any other breast disease? Yes No
4. Have you had any biopsies to the breasts and your findings? Yes No If yes, findings: fibrocystic / calcium nodule
   When:
   Where Right: Left:
5. Have you had breast cosmetic surgery or implants? Yes No
6. Have you had a mammogram in the last 12 months? Yes No
7. Have you had a mammogram in the last 5 years? Yes No
8. How many mammograms have you had in total? Total _____
9. At what age did you have your first mammogram? Age _____
10. Have you ever taken a contraceptive pill for more than 1 year? Yes No
11. Have you suffered cancer from the womb? Yes No
12. Have you had pharmaceutical hormone replacement therapy? Yes No
13. Do you have an annual physical examination by a doctor? Yes No
14. Do you perform a monthly breast self-examination? Yes No
15. How many births have you had? Total _____
16. What was your age when your first child was born? Age _____
17. Did your menstrual periods start before the age of 12? Yes No
18. Did your menstrual periods stop after the age of 50? Yes No
19. Do you smoke? Yes No
    How long? _____ Number of packs per day? _____
20. Have you had any of these breast symptoms in the last 6 months?



Pain	Yes	No	Left	Right	Both	Previous Illness?
Tenderness	Yes	No	Left	Right	Both	
Lump(s)	Yes	No	Left	Right	Both	
Change in breast size?	Yes	No	Left	Right	Both	Previous surgeries?
Area of skin thickening or dimpling?	Yes	No	Left	Right	Both	
Secretion of the Nipple?	Yes	No	Left	Right	Both	

Current Health Problems?

Current medications?

In order to receive a service, please read the following information, sign and date:

I have informed my practitioner of any condition which could affect the health and wellness of myself or my practitioner during this treatment. I do not hold Sedona Wellness, LLC, Sedona Wellness, LLC dba Pagosa Wellness or its entities liable for any adverse affects from services rendered and products or equipment used, at its location or at off-site events and retreats. Sedona wellness, LLC, Pagosa Wellness dba Sedona Wellness, and Sedona Wellness Institute, LLC is not responsible for damage, loss or theft of personal property or to my person.
I assume full responsibility for payment of services rendered by Sedona Wellness, LLC, Pagosa Wellness dba Sedona Wellness, LLC and its affiliates. The balance of payments due is required at the time of service.
SIGNATURE_____DATE_____

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

Pain indicated by a line/ X - If numbness indicate N
Scale 1 2 3 4 5 6 7 8 9 10 (level of pain). 10 is severe
Note: Scars an **S**, moles an **M** and fractures an **F**

Arm dominance: left handed right handed

Head/ Neck/ Chest

Do you suffer with:

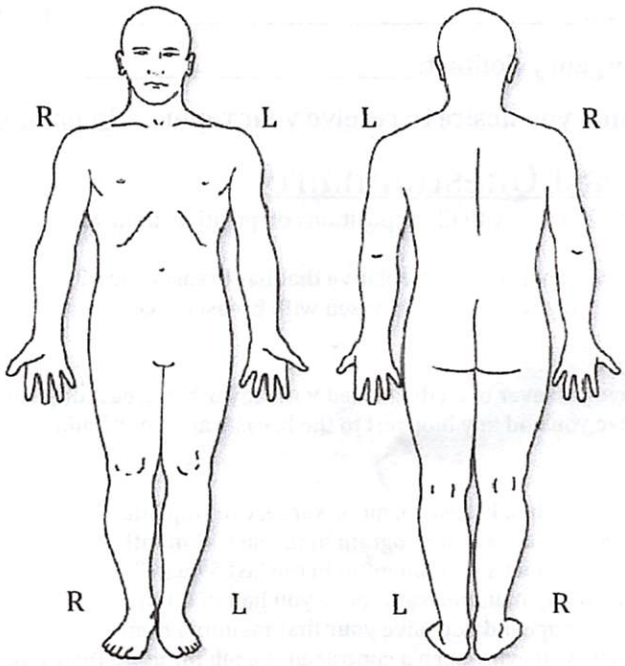
	Yes	No
Headaches	○	○
Allergies	○	○
TMJ or jaw clicking	○	○
Cold symptoms	○	○
Thyroid disorder	○	○
Neck pain	○	○
Upper back pain	○	○
Chest pain	○	○
Carotid artery disease	○	○
Lung disease	○	○
Family history of stroke	○	○
Sinus problems	○	○

Surgeries related to heart/ lungs/ spine:

_____

_____

_____



Abdomen

Do you suffer with (please circle):

Acid Reflux

Stomach Pain

Surgery or disease of the following:

Stomach _____

Spleen _____

Liver _____

Diabetes _____

Kidneys _____

Intestines _____

Arms/ Hands/ Legs/ Feet

Do you suffer pain and/or surgery:

	Left	Right
Shoulder	L	R
Elbow	L	R
Arm	L	R
Hands	L	R
Hip	L	R
Thigh	L	R
Knee	L	R
Leg	L	R
Ankle	L	R
Foot	L	R

Description of Accident:

_____

_____

_____

_____

_____

_____

_____

_____

Date of Accident: _____

Patient signature _____ Today's date: _____