



Confidential Questionnaire

Abdomen/Lower Back

Name _____ Birth Date _____ Today's Date _____

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.

Yes No

Abdomen & Lower Back

- | | Yes | No | | Yes | No |
|------------------------------------|-----------------------|-----------------------|--|-----------------------|-----------------------|
| 1. Do you suffer with acid reflux? | <input type="radio"/> | <input type="radio"/> | 3. Have you had surgery or disease in the: | | |
| | | | Stomach? | <input type="radio"/> | <input type="radio"/> |
| 2. Do you have pain in the: | | | Spleen? Left upper quadrant | <input type="radio"/> | <input type="radio"/> |
| Stomach? | <input type="radio"/> | <input type="radio"/> | Liver? Right upper quadrant | <input type="radio"/> | <input type="radio"/> |
| Below the right breast? | <input type="radio"/> | <input type="radio"/> | Kidneys? | <input type="radio"/> | <input type="radio"/> |
| Below the left breast? | <input type="radio"/> | <input type="radio"/> | Intestines? | <input type="radio"/> | <input type="radio"/> |
| Abdomen? | <input type="radio"/> | <input type="radio"/> | Abdomen? | <input type="radio"/> | <input type="radio"/> |
| Lower back? | <input type="radio"/> | <input type="radio"/> | Lower back? | <input type="radio"/> | <input type="radio"/> |

Do you have any special concerns or are there any details related to the information above?

(Check only if "yes")

- | | LT | RT | | LT | RT |
|------------------------------------|-----------------------|-----------------------|-----------------------------|-----------------------|-----------------------|
| 1. Do you suffer with pain in the: | | | 2. Have you had surgery to: | | |
| Leg? | <input type="radio"/> | <input type="radio"/> | Leg? | <input type="radio"/> | <input type="radio"/> |
| Sciatica? | <input type="radio"/> | <input type="radio"/> | Sciatica? | <input type="radio"/> | <input type="radio"/> |
| Buttocks/Hip? | <input type="radio"/> | <input type="radio"/> | Buttocks/Hip? | <input type="radio"/> | <input type="radio"/> |
| Knees? | <input type="radio"/> | <input type="radio"/> | Knees? | <input type="radio"/> | <input type="radio"/> |
| Ankles? | <input type="radio"/> | <input type="radio"/> | Ankles? | <input type="radio"/> | <input type="radio"/> |
| Feet? | <input type="radio"/> | <input type="radio"/> | Feet? | <input type="radio"/> | <input type="radio"/> |

Do you have any special concerns or are there any details related to the information above?