Medical Thermal Imaging
& Medical Colonics
4325 FM 2351 Suite 120 Friendswood, TX 77546
281-648-1026 Fax 281-648-2747
www.WholeBodyWellnessInc.com

NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State_____ ZIP_____

Shipping Address _____

_____

Home Phone (____) ____-_____ Work /Cell/Other Phone (____) ____-_____

e-mail address: _____

REFERRED BY:_____

Occupation _____ Employer_____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

Previous treatments for this complaint _____

_____

Other complaints or problems: (use separate sheet if needed) _____

_____

Current medications/drugs being taken: (use separate sheet if needed) _____

_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol_____

HISTORY:

List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date:_____

_____

Past Accidents or injuries: _____

_____

_____

Office Use Only:

Picture Id: _____.

NEW PATIENT INFORMATION FORM

Name: _____ Date_____

We do not diagnose.
We make no claims to cure any conditions.
We make no claims or imply any claims.
We do not claim that any supplemental material we may suggest will cure any condition.
We do not prescribe for, or treat diseases.

I understand the above statements. I understand that diet and nutrition are considered to be an inexact science, and the results obtained are not always constant or predictable. Medical Thermal Imaging is not a cure-all for any disease or infirmity.

I also understand that there is no guarantee of any results. Whether or not I participate in this program is my decision. I must make all decisions relative to my health.

I further understand that Joe Turcotte and Linda Turcotte ,and the staff, are not medical doctors in the so-called healing arts and are not attempting to portray themselves as, or conduct the activities of, a medical doctor.

If any representation has been made to me concerning any program or if I have any understanding about any program whose representations and/or understandings are contrary to any of the above statements, I will so indicate on the reverse side of this form.

Our work is limited to that of providing self-help education in natural health matters and the advocating of a healthy lifestyle. We ask you to affirm that you are not here seeking medical advice but rather seeking education advice, and not visiting on a mission of entrapment or as a representative of any state or local authority.

I understand that I am expected to meet on my scheduled appointment times. If, for any reason, I can not, I will reschedule at least 24 hours in advance. If I fail to reschedule at least 24 hours in advance my account will be charged for that visit.

==========

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any ____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier?_____

_____

I have read and understand this document.

SIGNED:_____ DATE _____

(03/12)

SYSTEMS SURVEY FORM

Client _____ Clinician _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Vegetarian: Yes ▪▪ No ▪▪

INSTRUCTIONS: Fill in only the circles which apply to you. Leave blank if you don't have the problem.

●○○ Fill in the circle marked 1 for MILD symptoms (occurs rarely).
○●○ Fill in the circle marked 2 for MODERATE symptoms (occurs several times a month).
○○● Fill in the circle marked 3 for SEVERE symptoms (occurs almost constantly).
○○○ **Leave circles BLANK if they don't apply to you!**

GROUP 1

	1 2 3		1 2 3		1 2 3	
1	○○○	Acid foods upset	8 ○○○	Gag easily	15 ○○○	Appetite reduced
2	○○○	Get chilled often	9 ○○○	Unable to relax; startles easily	16 ○○○	Cold sweats often
3	○○○	"Lump" in throat	10 ○○○	Extremities cold, clammy	17 ○○○	Fever easily raised
4	○○○	Dry mouth-eyes-nose	11 ○○○	Strong light irritates	18 ○○○	Neuralgia-like pains
5	○○○	Pulse speeds after meal	12 ○○○	Urine amount reduced	19 ○○○	Staring, blinks little
6	○○○	Keyed up - fail to calm	13 ○○○	Heart pounds after retiring	20 ○○○	Sour stomach often
7	○○○	Cut heals slowly	14 ○○○	"Nervous" stomach		

GROUP 2

	1 2 3		1 2 3		1 2 3	
21	○○○	Joint stiffness on arising	29 ○○○	Digestion rapid	37 ○○○	"Slow starter"
22	○○○	Muscle-leg-toe cramps at night	30 ○○○	Vomiting frequent	38 ○○○	Get "chilled" infrequently
23	○○○	"Butterfly" stomach, cramps	31 ○○○	Hoarseness frequent	39 ○○○	Perspire easily
24	○○○	Eyes or nose watery	32 ○○○	Breathing irregular	40 ○○○	Circulation poor, sensitive to cold
25	○○○	Eyes blink often	33 ○○○	Pulse slow; feels "irregular"		
26	○○○	Eyelids swollen, puffy	34 ○○○	Gagging reflex slow	41 ○○○	Subject to colds, asthma, bronchitis
27	○○○	Indigestion soon after meals	35 ○○○	Difficulty swallowing		
28	○○○	Always seems hungry; feels "lightheaded" often	36 ○○○	Constipation, diarrhea alternating		

GROUP 3

	1 2 3		1 2 3		1 2 3	
42	○○○	Eat when nervous	49 ○○○	Heart palpitates if meals missed or delayed	53 ○○○	Crave candy or coffee in afternoons
43	○○○	Excessive appetite				
44	○○○	Hungry between meals	50 ○○○	Afternoon headaches	54 ○○○	Moods of depression - "blues" or melancholy
45	○○○	Irritable before meals	51 ○○○	Overeating sweets upsets		
46	○○○	Get "shaky" if hungry	52 ○○○	Awaken after few hours sleep - hard to get back to sleep	55 ○○○	Abnormal craving for sweets or snacks
47	○○○	Fatigue, eating relieves				
48	○○○	"Lightheaded" if meals delayed				

GROUP 4

	1 2 3		1 2 3		1 2 3	
56	○○○	Hands and feet go to sleep easily, numbness	63 ○○○	Get "drowsy" often	68 ○○○	Bruise easily, "black and blue" spots
57	○○○	Sigh frequently, "air hunger"	64 ○○○	Swollen ankles, worse at night	69 ○○○	Tendency to anemia
58	○○○	Aware of "breathing heavily"	65 ○○○	Muscle cramps, worse during exercise; get "charley horses"	70 ○○○	"Nose bleeds" frequent
59	○○○	High altitude discomfort	66 ○○○	Shortness of breath on exertion	71 ○○○	Noises in head, or "ringing in ears"
60	○○○	Opens windows in closed rooms	67 ○○○	Dull pain in chest or radiating into left arm, worse on exertion	72 ○○○	Tension under the breastbone, or feeling of "tightness", worse on exertion
61	○○○	Susceptible to colds and fevers				
62	○○○	Afternoon "yawner"				

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

1 2 3

73 ○○○ Dizziness
74 ○○○ Dry skin
75 ○○○ Burning feet
76 ○○○ Blurred vision
77 ○○○ Itching skin and feet
78 ○○○ Excessive falling hair
79 ○○○ Frequent skin rashes
80 ○○○ Bitter, metallic taste in mouth in mornings
81 ○○○ Bowel movements painful or difficult
82 ○○○ Worrier, feels insecure
83 ○○○ Feeling queasy; headache over eyes
84 ○○○ Greasy foods upset
85 ○○○ Stools light colored
86 ○○○ Skin peels on foot soles
87 ○○○ Pain between shoulder blades
88 ○○○ Use laxatives
89 ○○○ Stools alternate from soft to watery
90 ○○○ History of gallbladder attacks or gallstones
91 ○○○ Sneezing attacks
92 ○○○ Dreaming, nightmare type bad dreams
93 ○○○ Bad breath (halitosis)
94 ○○○ Milk products cause distress
95 ○○○ Sensitive to hot weather
96 ○○○ Burning or itching anus
97 ○○○ Crave sweets

GROUP 6

1 2 3

98 ○○○ Loss of taste for meat
99 ○○○ Lower bowel gas several hours after eating
100 ○○○ Burning stomach sensations, eating relieves
101 ○○○ Coated tongue
102 ○○○ Pass large amounts of foul-smelling gas
103 ○○○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104 ○○○ Mucous colitis or "irritable bowel"
105 ○○○ Gas shortly after eating
106 ○○○ Stomach "bloating" after

GROUP 7

(A)

1 2 3

107 ○○○ Insomnia
108 ○○○ Nervousness
109 ○○○ Can't gain weight
110 ○○○ Intolerance to heat
111 ○○○ Highly emotional
112 ○○○ Flush easily
113 ○○○ Night sweats
114 ○○○ Thin, moist skin
115 ○○○ Inward trembling
116 ○○○ Heart palpitates
117 ○○○ Increased appetite without weight gain
118 ○○○ Pulse fast at rest
119 ○○○ Eyelids and face twitch
120 ○○○ Irritable and restless
121 ○○○ Can't work under pressure

(B)

1 2 3

122 ○○○ Increase in weight
123 ○○○ Decrease in appetite
124 ○○○ Fatigue easily
125 ○○○ Ringing in ears
126 ○○○ Sleepy during day
127 ○○○ Sensitive to cold
128 ○○○ Dry or scaly skin
129 ○○○ Constipation
130 ○○○ Mental sluggishness
131 ○○○ Hair coarse, falls out
132 ○○○ Headaches upon arising, wear off during day
133 ○○○ Slow pulse, below 65
134 ○○○ Frequency of urination
135 ○○○ Impaired hearing
136 ○○○ Reduced initiative

(C)

1 2 3

137 ○○○ Failing memory
138 ○○○ Low blood pressure
139 ○○○ Increased sex drive
140 ○○○ Headaches, "splitting or rending" type
141 ○○○ Decreased sugar tolerance

(D)

1 2 3

142 ○○○ Abnormal thirst
143 ○○○ Bloating of abdomen
144 ○○○ Weight gain around hips or waist
145 ○○○ Sex drive reduced or lacking
146 ○○○ Tendency to ulcers, colitis
147 ○○○ Increased sugar tolerance
148 ○○○ Women: menstrual disorders
149 ○○○ Young girls: lack of menstrual function

(E)

1 2 3

150 ○○○ Dizziness
151 ○○○ Headaches
152 ○○○ Hot flashes
153 ○○○ Increased blood pressure
154 ○○○ Hair growth on face or body (female)
155 ○○○ Sugar in urine (not diabetes)
156 ○○○ Masculine tendencies (female)

(F)

1 2 3

157 ○○○ Weakness, dizziness
158 ○○○ Chronic fatigue
159 ○○○ Low blood pressure
160 ○○○ Nails weak, ridged
161 ○○○ Tendency to hives
162 ○○○ Arthritic tendencies
163 ○○○ Perspiration increase
164 ○○○ Bowel disorders
165 ○○○ Poor circulation
166 ○○○ Swollen ankles
167 ○○○ Crave salt
168 ○○○ Brown spots or bronzing of skin
169 ○○○ Allergies - tendency to asthma
170 ○○○ Weakness after colds, influenza
171 ○○○ Exhaustion - muscular and nervous
172 ○○○ Respiratory disorders

SYSTEMS SURVEY FORM - PAGE 3

GROUP 8

	1	2	3			1	2	3			1	2	3	
173	○	○	○	Apprehension	183	○	○	○	Noise sensitivity	193	○	○	○	Insomnia
174	○	○	○	Irritability	184	○	○	○	Acoustic hallucinations	194	○	○	○	Anxiety
175	○	○	○	Morbid fears	185	○	○	○	Tendency to cry without reason	195	○	○	○	Anorexia
176	○	○	○	Never seems to get well	186	○	○	○	Hair is coarse and/or thinning	196	○	○	○	Inability to concentrate; confusion
177	○	○	○	Forgetfulness	187	○	○	○	Weakness					
178	○	○	○	Indigestion	188	○	○	○	Fatigue	197	○	○	○	Frequent stuffy nose; sinus infections
179	○	○	○	Poor appetite	189	○	○	○	Skin sensitive to touch					
180	○	○	○	Craving for sweets	190	○	○	○	Tendency toward hives	198	○	○	○	Allergy to some foods
181	○	○	○	Muscular soreness	191	○	○	○	Nervousness	199	○	○	○	Loose joints
182	○	○	○	Depression; feelings of dread	192	○	○	○	Headache					

FEMALE ONLY

	1	2	3			1	2	3	
200	○	○	○	Very easily fatigued	206	○	○	○	Menstruate too frequently
201	○	○	○	Premenstrual tension	207	○	○	○	Vaginal discharge
202	○	○	○	Painful menses	208			○	Hysterectomy / ovaries removed
203	○	○	○	Depressed feelings before menstruation	209	○	○	○	Menopausal hot flashes
204	○	○	○	Menstruation excessive and prolonged	210	○	○	○	Menses scanty or missed
					211	○	○	○	Acne, worse at menses
205	○	○	○	Painful breasts	212	○	○	○	Depression of long standing

MALE ONLY

	1	2	3	
213	○	○	○	Prostate trouble
214	○	○	○	Urination difficult or dribbling
215	○	○	○	Night urination frequent
216	○	○	○	Depression
217	○	○	○	Pain on inside of legs or heels
218	○	○	○	Feeling of incomplete bowel evacuation
219	○	○	○	Lack of energy
220	○	○	○	Migrating aches and pains
221	○	○	○	Tire too easily
222	○	○	○	Avoids activity
223	○	○	○	Leg nervousness at night
224	○	○	○	Diminished sex drive

IMPORTANT

Please list the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES

Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES

The 2nd and 3rd day of flow OR any 5 days in a row

MALES

Any 2 days during the month

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____

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New Patient Introduction Form

Patient Name: **Date:**

1. **Chief Concerns:**

2. **Medications and/or Nutritional Supplements currently on:**

3. **Dietary Intake for 2 days before appointment:**

Breakfast:	**Breakfast:**
Snacks:	**Snacks:**
Lunch:	**Lunch:**
Snacks:	**Snacks:**
Dinner:	**Dinner:**
Snacks:	**Snacks:**