



Medical Thermal Imaging & Medical Colonics

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www.MedicalThermalImaging.com

NEW PATIENT INFORMATION FORM

Page 1 of 2

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.

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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? _____

SIGNED: _____ DATE _____

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

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

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

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| <p>1 2 3</p> <p>42 ○○○○ Eat when nervous</p> <p>43 ○○○○ Excessive appetite</p> <p>44 ○○○○ Hungry between meals</p> <p>45 ○○○○ Irritable before meals</p> <p>46 ○○○○ Get "shaky" if hungry</p> <p>47 ○○○○ Fatigue, eating relieves</p> <p>48 ○○○○ "Lightheaded" if meals delayed</p> | <p>1 2 3</p> <p>49 ○○○○ Heart palpitates if meals missed or delayed</p> <p>50 ○○○○ Afternoon headaches</p> <p>51 ○○○○ Overeating sweets upsets</p> <p>52 ○○○○ Awaken after few hours sleep - hard to get back to sleep</p> | <p>1 2 3</p> <p>53 ○○○○ Crave candy or coffee in afternoons</p> <p>54 ○○○○ Moods of depression - "blues" or melancholy</p> <p>55 ○○○○ Abnormal craving for sweets or snacks</p> |
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GROUP 4

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

GROUP 5

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| <p>1 2 3</p> <p>73 ○○○ Dizziness</p> <p>74 ○○○ Dry skin</p> <p>75 ○○○ Burning feet</p> <p>76 ○○○ Blurred vision</p> <p>77 ○○○ Itching skin and feet</p> <p>78 ○○○ Excessive falling hair</p> <p>79 ○○○ Frequent skin rashes</p> <p>80 ○○○ Bitter, metallic taste in mouth in mornings</p> <p>81 ○○○ Bowel movements painful or difficult</p> <p>82 ○○○ Worrier, feels insecure</p> | <p>1 2 3</p> <p>83 ○○○ Feeling queasy; headache over eyes</p> <p>84 ○○○ Greasy foods upset</p> <p>85 ○○○ Stools light colored</p> <p>86 ○○○ Skin peels on foot soles</p> <p>87 ○○○ Pain between shoulder blades</p> <p>88 ○○○ Use laxatives</p> <p>89 ○○○ Stools alternate from soft to watery</p> <p>90 ○○○ History of gallbladder attacks or gallstones</p> | <p>1 2 3</p> <p>91 ○○○ Sneezing attacks</p> <p>92 ○○○ Dreaming, nightmare type bad dreams</p> <p>93 ○○○ Bad breath (halitosis)</p> <p>94 ○○○ Milk products cause distress</p> <p>95 ○○○ Sensitive to hot weather</p> <p>96 ○○○ Burning or itching anus</p> <p>97 ○○○ Crave sweets</p> |
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GROUP 6

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| <p>1 2 3</p> <p>98 ○○○ Loss of taste for meat</p> <p>99 ○○○ Lower bowel gas several hours after eating</p> <p>100 ○○○ Burning stomach sensations, eating relieves</p> | <p>1 2 3</p> <p>101 ○○○ Coated tongue</p> <p>102 ○○○ Pass large amounts of foul-smelling gas</p> <p>103 ○○○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.</p> | <p>1 2 3</p> <p>104 ○○○ Mucous colitis or "irritable bowel"</p> <p>105 ○○○ Gas shortly after eating</p> <p>106 ○○○ Stomach "bloating" after</p> |
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GROUP 7

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| <p>1 2 3 (A)</p> <p>107 ○○○ Insomnia</p> <p>108 ○○○ Nervousness</p> <p>109 ○○○ Can't gain weight</p> <p>110 ○○○ Intolerance to heat</p> <p>111 ○○○ Highly emotional</p> <p>112 ○○○ Flush easily</p> <p>113 ○○○ Night sweats</p> <p>114 ○○○ Thin, moist skin</p> <p>115 ○○○ Inward trembling</p> <p>116 ○○○ Heart palpitates</p> <p>117 ○○○ Increased appetite without weight gain</p> <p>118 ○○○ Pulse fast at rest</p> <p>119 ○○○ Eyelids and face twitch</p> <p>120 ○○○ Irritable and restless</p> <p>121 ○○○ Can't work under pressure</p> | <p>1 2 3 (C)</p> <p>137 ○○○ Failing memory</p> <p>138 ○○○ Low blood pressure</p> <p>139 ○○○ Increased sex drive</p> <p>140 ○○○ Headaches, "splitting or rending" type</p> <p>141 ○○○ Decreased sugar tolerance</p> <p>1 2 3 (D)</p> <p>142 ○○○ Abnormal thirst</p> <p>143 ○○○ Bloating of abdomen</p> <p>144 ○○○ Weight gain around hips or waist</p> <p>145 ○○○ Sex drive reduced or lacking</p> <p>146 ○○○ Tendency to ulcers, colitis</p> <p>147 ○○○ Increased sugar tolerance</p> <p>148 ○○○ Women: menstrual disorders</p> <p>149 ○○○ Young girls: lack of menstrual function</p> | <p>1 2 3 (E)</p> <p>150 ○○○ Dizziness</p> <p>151 ○○○ Headaches</p> <p>152 ○○○ Hot flashes</p> <p>153 ○○○ Increased blood pressure</p> <p>154 ○○○ Hair growth on face or body (female)</p> <p>155 ○○○ Sugar in urine (not diabetes)</p> <p>156 ○○○ Masculine tendencies (female)</p> <p>1 2 3 (F)</p> <p>157 ○○○ Weakness, dizziness</p> <p>158 ○○○ Chronic fatigue</p> <p>159 ○○○ Low blood pressure</p> <p>160 ○○○ Nails weak, ridged</p> <p>161 ○○○ Tendency to hives</p> <p>162 ○○○ Arthritic tendencies</p> <p>163 ○○○ Perspiration increase</p> <p>164 ○○○ Bowel disorders</p> <p>165 ○○○ Poor circulation</p> <p>166 ○○○ Swollen ankles</p> <p>167 ○○○ Crave salt</p> <p>168 ○○○ Brown spots or bronzing of skin</p> <p>169 ○○○ Allergies - tendency to asthma</p> <p>170 ○○○ Weakness after colds, influenza</p> <p>171 ○○○ Exhaustion - muscular and nervous</p> <p>172 ○○○ Respiratory disorders</p> |
| <p>1 2 3 (B)</p> <p>122 ○○○ Increase in weight</p> <p>123 ○○○ Decrease in appetite</p> <p>124 ○○○ Fatigue easily</p> <p>125 ○○○ Ringing in ears</p> <p>126 ○○○ Sleepy during day</p> <p>127 ○○○ Sensitive to cold</p> <p>128 ○○○ Dry or scaly skin</p> <p>129 ○○○ Constipation</p> <p>130 ○○○ Mental sluggishness</p> <p>131 ○○○ Hair coarse, falls out</p> <p>132 ○○○ Headaches upon arising, wear off during day</p> <p>133 ○○○ Slow pulse, below 65</p> <p>134 ○○○ Frequency of urination</p> <p>135 ○○○ Impaired hearing</p> <p>136 ○○○ Reduced initiative</p> | | |



ACCT
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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: