



# Masters of Healing

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Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 E-Mail: \_\_\_\_\_ Home Ph. # \_\_\_\_\_ Cell Ph.# \_\_\_\_\_  
 Emergency Contact (Name/Tel) \_\_\_\_\_ Last Thermogram \_\_\_\_\_

**Breast Questionnaire** - Receive the report: In person/ Mail/ E-Mail Occupation: \_\_\_\_\_ 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 # Taken \_\_\_\_\_ First Taken? / /

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

Hormone therapy? **Yes / No**

Doctors last breast exam? / /

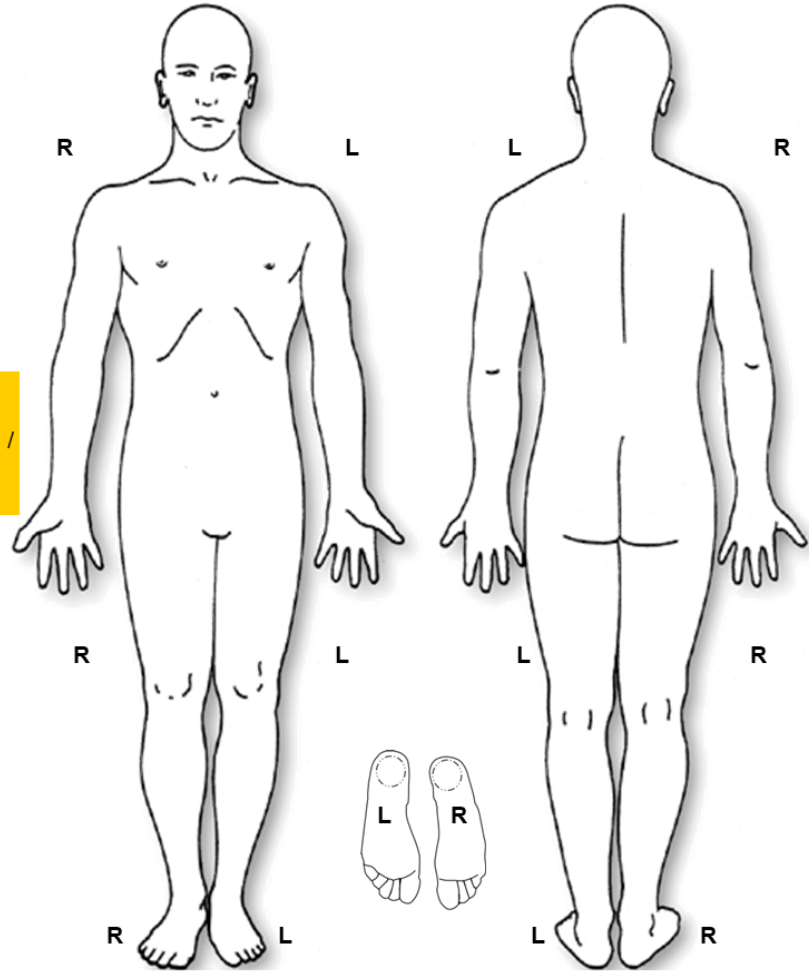
Monthly breast self exams? **Yes / No**

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

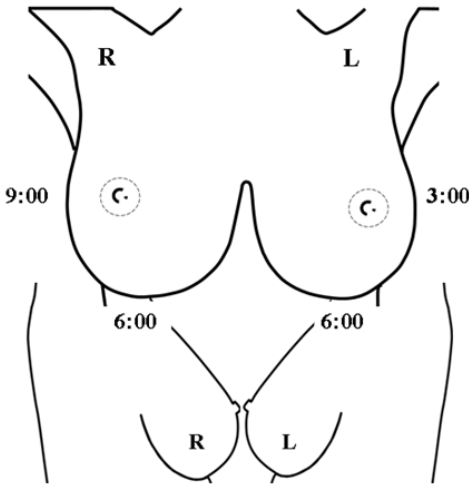
Menstrual stopped after 50 ? **Yes / No**

Total # births? \_\_\_\_\_, your age of first bom? \_\_\_\_\_

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.



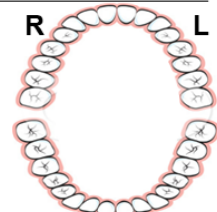
**Breast symptoms in the last 6 months?** Please demonstrate symptoms with following symbols: "T" for Tenderness; "L" for Lumps; "D/T" for Nipple Dimpling / Thickening. Change in Size "CS"; "NS" Nipple Secretion, Biopsy "B", presently breast feeding: **Yes / No**



Main complaint: \_\_\_\_\_

**Client 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 Gregory Melvin, DC and Masters of Healing. We are hereby exercising our right of freedom of association. This means that our association activities are restricted to the private domain only and outside the government entities, agencies, officers, agents, contractors and other representatives as provided by law.

Current Medication: \_\_\_\_\_



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

Client Signature : \_\_\_\_\_  
 Signature Authorizing Payment

Date: \_\_\_\_\_