



**Be Wholistic with Paula, Inc.**  
**Body Intake Form Infrared Imaging**

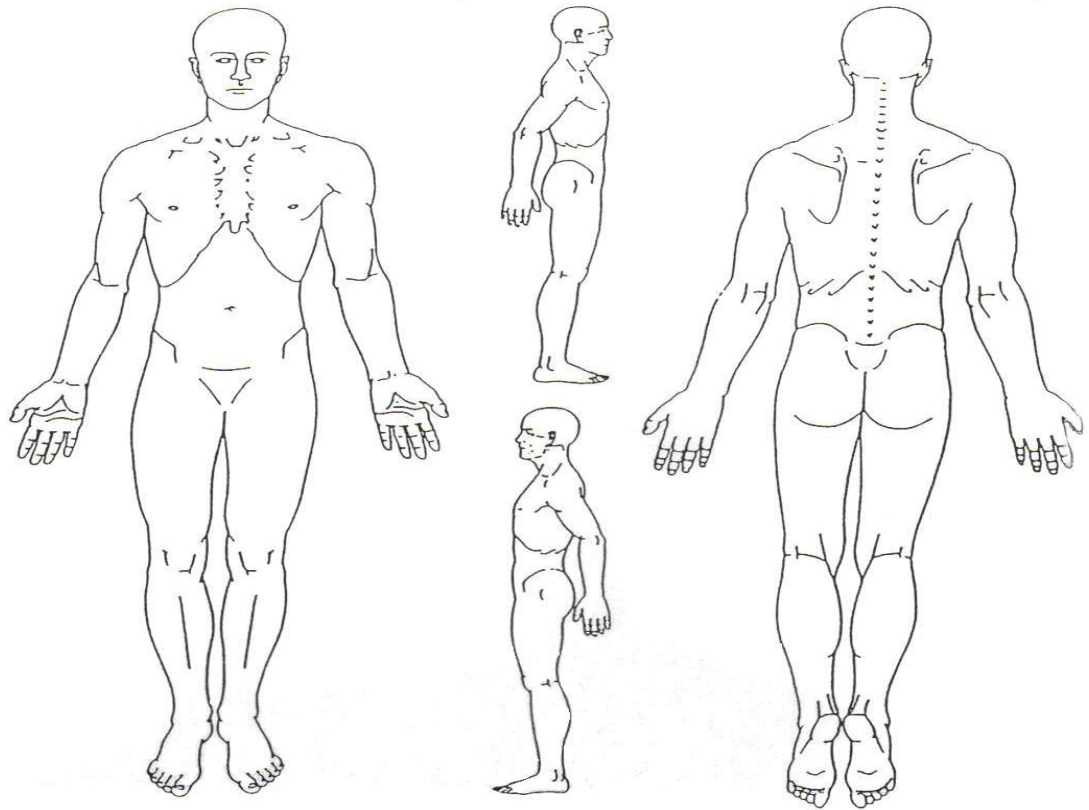
Phone: 954-203-8992 | Email: [info@managenutrition.com](mailto:info@managenutrition.com) | Web: [www.managenutrition.com](http://www.managenutrition.com)

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ ☐ R ☐ L Handed  
Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Please mark the area and  
type of pain on the  
drawing using the  
following code:

**N** – Numbness  
**P** – Pain  
**T** – Tingling  
**A** – Ache  
**S** – Soreness  
**ST** – Stiffness

Please mark all scars  
using the following: ++++



**Right**

**Left**

**Left**

**Left**

**Right**

What are your current complaints? \_\_\_\_\_

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Have you ever been diagnosed with cancer? ☐ Y ☐ N

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

Do you have any current diagnoses / diseases / conditions? ☐ Y ☐ N

List diagnoses / diseases / conditions: \_\_\_\_\_

Have you had any surgeries? ☐ Y ☐ N

List surgeries and dates: \_\_\_\_\_

Have you had any broken bones / fractures? ☐ Y ☐ N

List bones broken / fractures and dates: \_\_\_\_\_

Have you had any dental work in the past 2 months? ☐ Y ☐ N

Type of work and dates (give location – ex. rear upper molars): \_\_\_\_\_

Have you had a flu, cold, or respiratory illness in the past month? ☐ Y ☐ N

Do you suffer from any condition other than that which has been listed previously? ☐ Y ☐ N

If yes, what is it? \_\_\_\_\_

I have completed this 2-page form to the best of my ability.

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

**Office Use Only:**

Tech: \_\_\_\_\_

Re-Exam: ☐ Y ☐ N

Pt T: \_\_\_\_\_ F Rm T: \_\_\_\_\_ C

Image Series: ☐ Upper Body ☐ Lower Body ☐ Full Body ☐ Maxillofacial ☐ ROI