Patient Preparation Sheet/Full Body

Full Body or Region of Interest Health Screening with Digital Infrared Thermal Imaging (Thermography)

Purpose of test

Determine the cause of pain.
Evaluate sensory-nerve irritation or significant soft-tissue injury.
Define a previously diagnosed injury or condition.
Identify an abnormal area for further diagnostic testing.
Early detection of lesions.
Monitor progress of healing and rehabilitation.
Provide objective evidence.

Patient Preparation

Prior to your appointment do not (on the day of):

- have physical therapy or electromyography
- use a tanning booth and avoid overexposure to the sun
- smoke (for 2 hours before the test)
- Use lotions, powders, anti-perspirants, or makeup
- have strenuous exercise
- shave any part of your body

Do not have acupuncture treatment 3 days prior to appointment. Wait 3 months post surgery, and 6 months post radiation therapy before scheduling an appointment.

If your hair falls below your neck, you should wear it clipped or pinned up.

Wear loose fitting clothes and no jewelry around the neck.

No changes necessary for diet or medication.

General Information:

Procedure is non-invasive, no-contact, no radiation and FDA Approved.

Disrobing – Remove all clothing and jewelry. Put on a gown or sarong supplied. Inform your thermographer if you had any recent skin lesions on your body; the inflammation can cause a false positive result.

Thermography is performed by a certified clinical thermographer and is completely private.

There are no risks or side effects.

Average time for the appointment is 30 min. for one or two body regions, 1 hour for half or full body.

Please bring your healthcare provider's complete name and address if you want a copy of report mailed to him/her.

We gladly accept personal check, cash, VISA/ MC for payment.

You are welcome to bring a companion or partner to be present during the scan.

Patient Intake Form

Name _____

DOB _____ Age _____

Street _____

City _____

State _____

Zip _____

Occupation _____

Email _____

For office use only:

Patient ID # _____ Report ref # _____

IB BB YB HB FB 1ROI 2ROI

Referred by _____

Location _____ Scans uploaded _____

Data uploaded _____ Called _____

Next Apt _____ Reminder Sent _____

Pymt _____ Ck # _____ V M D FSA

Phone (please include area code) (H) _____ (W) _____

(C) _____ Leave message with results? Yes / No

Reason for today's visit: _____

_____

Current Symptoms: _____

_____

Current Treatment: _____

_____

Previous Illnesses: _____

_____

Previous Surgeries/Dates: _____

_____

Injuries/Dates: _____

_____

Current Medication(s): _____

_____

This information is confidential. All information is correct to my knowledge.

Signature: _____ Date: _____

Full Body Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting thermologist and any other practitioner that you specify.

Name: Birth date:

Address: City: Zip:

Phone: Your Doctor:

Please use the symbols below to indicate areas of :

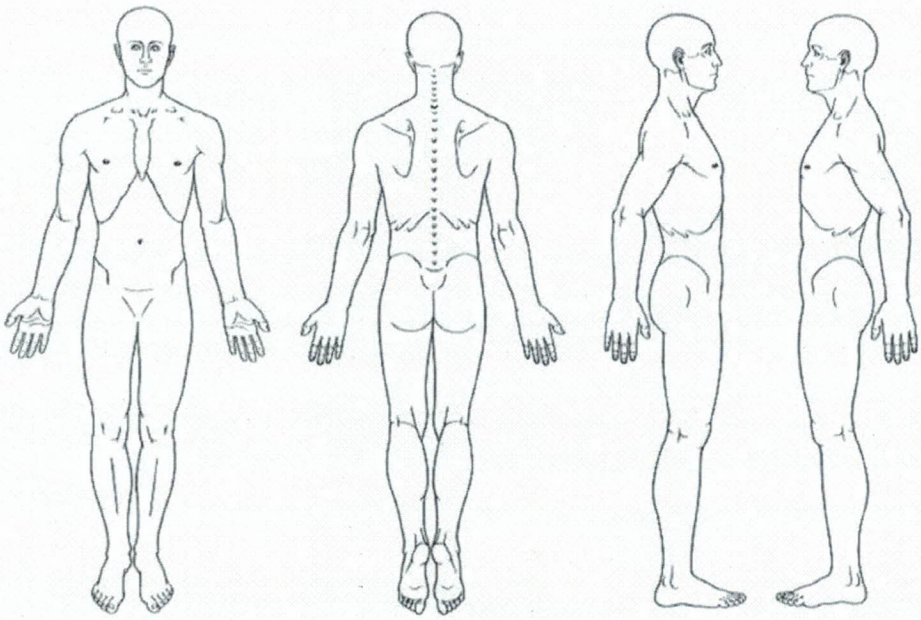
Main Pain ✻

Secondary Pain ❍

Numbness ////////

Pins and needles ::::::::

Skin lesions / scarring



Do you know what triggered the pain ?

_____

Does anything relieve it ?

_____

Does anything aggravate it ?

_____

Has it changed since it began ?

_____

Have you had any treatment ?

_____

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any 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 certify that I have read and understand the statements above and consent to the examination.

Signature_____

Breast Questionnaire

Name:_____ Birthdate:_____

1. Do you have any close relative who has had breast cancer?	Yes	No
2. Have you ever been diagnosed with breast cancer?	Yes	No
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	Yes	No
4. Have you had any biopsies or surgeries to your breasts?	Yes	No
5. Have you had any breast cosmetic surgery or implants?	Yes	No
6. Have you had a mammogram in the past 12 months?	Yes	No
7. Have you had a mammogram in the past 5 years?	Yes	No
8. Have you had abnormal results from any breast testing?	Yes	No
9. Have you ever taken a contraceptive pill for more than 1 year?	Yes	No
10. Have you suffered with cancer of the womb?	Yes	No
11. Have you had pharmaceutical hormone replacement therapy?	Yes	No
12. Do you have an annual physical examination by the doctor?	Yes	No
13. Do you perform a monthly breast self exam?	Yes	No

14. How many mammograms have you had in total? _____
15. What was your age when you had your first mammogram? _____
16. How many births have you had? _____ Your age at birth of first child:_____
17. Did your periods start before the age of 12? _____ Or finish after the age of 50? ____
18. Do you smoke? Yes__ No __ Never __ Not in last 12 months __ Not in last 5 years__

Have you recently had any of these breast symptoms:	**Right Breast**	**Left Breast**
Pain	❑	❑
Tenderness	❑	❑
Lumps	❑	❑
Change in breast size	❑	❑
Areas of skin thickening or dimpling	❑	❑
Secretions of the nipple	❑	❑

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Signature _____ Today's Date _____

Extended Breast Questionnaire

Patient Name: _____ Date: _____

Diagnosed with breast cancer:

Cancer type: Metastatic___ Local___ Lymph node involvement___

When diagnosed: Month_____ Year_____

Where (left breast): UO____ UI____ LO____ LI____ Nipple____

Where (right breast): UO____ UI____ LO____ LI____ Nipple____

Treatment: Surgery____ Chemo____ Radiation____ Other____ None____

Diagnosed with other breast disease:

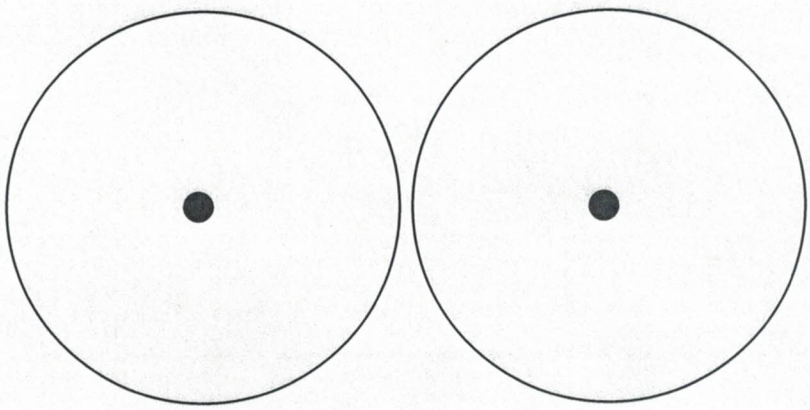
Disease type: Fibrocystic____ Cystic____ Mastitis____ Abscess____ Other ____

(please report other types of disease in the history)

Breast biopsies or surgery:

Where (left breast): UO____ UI____ LO____ LI____ Nipple____

Where (right breast): UO____ UI____ LO____ LI____ Nipple____



Patient Review of Body Systems

Name:_____ Date:_____

Constitutional

___Fevers/Chills/Sweats

___Unexplained weight loss/gain

___Fatigue/weakness

___Excessive thirst or urination

Musculo-SKeletal

___Muscle/Joint Pain

Ears/Nose/Throat

___Difficulty hearing/ringing

___Hay Fever/Allergies

Cardiovascular

___Chest Pain/Discomfort

___Leg Pain w/Exercise

___Palpitations

Other (please specify)

_____

_____

Dental

___Extractions

___Crowns

___Root Canal

___Gum Disease

___Fillings

___Other

Respiratory

___Cough/Wheeze

___Difficulty Breathing

Gastrointestinal

___Heartburn/Reflux

___Nausea/Vomiting/Diarrhea

___Large bowel dysfunction

___Abdominal Pain

Skin

___Rash or Mole

Neurological

___Numbness

___Headaches

Organ Dysfunction

_____

_____

Blood/Lymphatic

___Unexplained Lumps

___Easy Bruising

General Medical History: Past and Current medical problems (please include dates)

___Heart Disease: (specify)

___Diabetes

___Asthma/Lung Disease

___Accidents

___Other: (specify)

___High Blood Pressure

___Thyroid Problem

___Chemical Exposure

___Injuries

___High Cholesterol

___Kidney Disease

___Cancer: (specify)

_____

_____

Family History: Please indicate the current status of your immediate family members (Mother, Father, Sibling, Grandparent, Aunt, Uncle)

___High Cholesterol

___Heart Disease

___Bleeding or Clotting

___Asthma/COPD

___Cancer: type _____

___High Blood Pressure

___Stroke

___Genetic Disorders

___Other

___Diabetes

Authorization to Use or Disclose Protected Health Information
Living Well Thermography

Patient Name:_____

Address: _____

Date of Birth: _____ Date of Request:_____

As required by the Privacy Regulations, *Living Well Thermography* may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of (describe in detail)
Interpretation of said images

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature or Patient or Patient's Authorized Representative *Date*

_____ _____
Authorized Signature of Facility *Date*