Patient Preparation Sheet

Health Screening with Digital Infrared Thermal Imaging (Thermography)

Purpose of Test

Early detection of abnormal changes in the body requiring further diagnostic testing

Patient Prep - Day of Test

DO NOT:

- use a tanning booth and avoid overexposure to the sun
- have strenuous exercise
- use heating pads or cold packs
- shave or us lotions, powders, anti-perspirants or makeup
- smoke 2 hours prior
- have physical therapy or electromyography

Do not have acupuncture treatments within 3 days prior to appointment. Wait 3 months post surgery, and 6 months post radiation therapy to schedule an appointment.

Wear loose fitting clothing and remove all jewelry.

Wear hair pinned or clipped up as to see hair line.

No changes necessary for diet or medication.

General Information

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

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

Disrobing- Remove all clothing and jewelry. Put on a supplied gown or sarong. Inform your thermographer if you had any recent skin lesions, inflammation may cause a false positive result.

There are no risks and no side effects

We gladly except personal check, cash and credit card for payment

Patient Intake Form

Name _____

DOB _____ Age _____

Address _____

City _____

State _____

Zip _____

Occupation _____

Email _____

For office use only:

Patient ID # _____ Report # _____

IB BB AB WW HB FB

Referred by _____

Location _____ Next F/U Month _____

Scans / Data uploaded _____

Payment _____ V M D AMX FSA

Phone (C) _____ (H) _____

Referring Physician _____ Primary Physician _____

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: _____

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Full Body Questionnaire

Name_____ **Date Of Birth**_____

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

Please use the symbols below to indicate areas of :

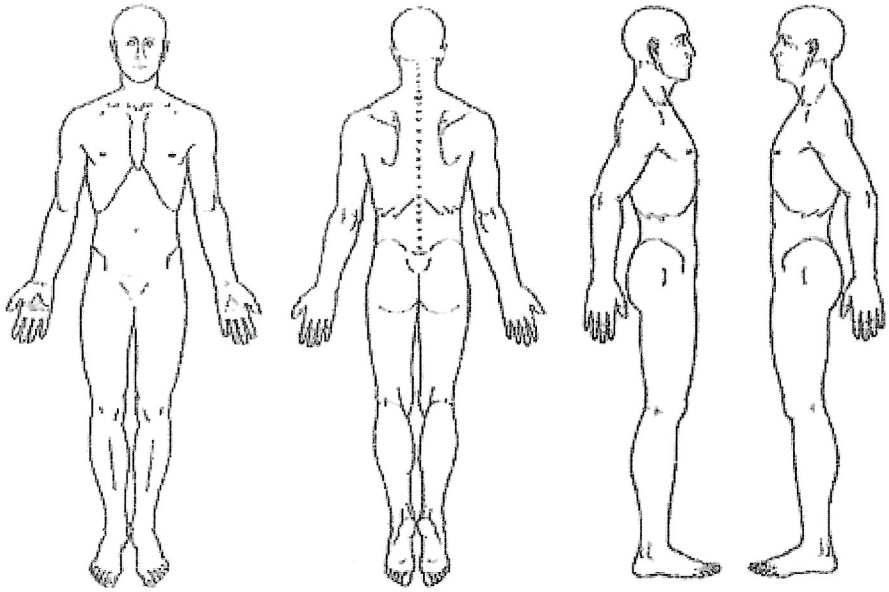
Main Pain ✻

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_____

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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

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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**

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