

Patient Information: Screening with Digital Infrared Thermal Imaging

Purpose of test:

- Help in determining cause of pain.
- For the early detection of disease and pathology.
- Evaluate sensory-nerve irritation or significant soft-tissue injury.
- To define a previously diagnosed injury or condition.
- To identify an abnormal area for further diagnostic testing.
- To follow progress of healing and rehabilitation.
- To provide objective evidence.

Patient preparation:

- Do not have physical therapy or electromyography on the same day thermography is performed.
- Do not smoke for 2 hours before the test.
- Do not chew gum 2 hours before the test.
- Do not use under arm deodorants, lotions, make-up, liniments or powder on your body or face on the day of test. This is particularly important for breast studies.
- Avoid sun exposure on day of test.
- Diet – No changes necessary
- Medicines – No changes necessary
- Disrobing – You will be removing clothing down to underwear. Men, please wear briefs rather than boxer shorts for Full Body scans.
- Removing jewelry. Putting on a supplied gown.
Inform your Thermographer if you have had any recent skin lesions; the inflammation can cause a false positive result.

Description of test:

- Patient time for test: approx. 15-30 minutes.
- You are given time for your skin temperature to equalize with the room temperature. Examining rooms can feel cool as your body adjusts to room temperature.
- Thermal Images are taken of the whole body, or just areas under investigation.
- A cervical assessment would typically include: head and neck, upper trunk & arms.
- A lumbar assessment would typically include: low back, pelvis, and legs.
- Neurological testing can include a "cold stress test", this involves placing a hand or foot into a bowl of cool water, or having a cool gel pack applied to any part of the body.
The procedure is totally non-invasive, the camera does not emit radiation of any kind.

Frequently asked questions:

- Who performs the test? A Female Clinical Thermographer.
Any risks or side effects? None, Procedure is non-invasive, non-contact and no radiation.

You are welcome to bring a companion or partner to be present at the examination.

While participation in a DITI early detection program can increase your chance of detecting and monitoring breast disease, as with all other tests, it is still not a 100% guarantee of detection.

Confidential Client Case History

Patient Information

Patient ID: _____

Name Mr Mrs Ms Dr Date: _____

First/MI/Last _____

Address _____

City/State/Zip _____

Sex: F M Age _____ DOB _____

Occupation: _____

Learned of us via: _____

Phone Numbers

Phone (H): _____

Phone (W): _____

Cell: _____

E-mail: _____

Name & Address of Health Care Provider you wish report sent to: _____

Were you referred by this Provider? Yes ___ No ___
 (NOTE: In the absence of address information, reports will be mailed to the patient for submission to their provider.)

Current Medications	Other Treatments	Surgeries/Dates	Location of scars/tattoo's

Fractures/Injuries:

Smoking Hx:
 Do you smoke? ___Yes ___Never ___ Not in last 12 months ___ Not in last 5 years Began age _____ For # Years _____

Family Health History (Any Cancer/Type; Heart Disease; Diabetes)

Maternal Side Key: M= Mother; S= Sister; B= Brother MA/MU= Maternal Aunt/Uncle MGM/MGF= Maternal Grandmother/Grandfather _____ _____ _____	Paternal Side Key: F= Father PA/PU = Paternal Aunt/Uncle PGM/PGF = Paternal Grandmother/Grandfather _____ _____ _____
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Two (2) copies of the report and images will be mailed to you, one for your file, the second for the health care provider of your choice. Additional copies are available upon request at \$15 per set.
 This information is confidential. All information is correct to my knowledge.

Signed _____ Date _____

For Official Use Only. IM _____ C _____ DRP _____ A _____
 Scan Type: _____ Location: _____ / _____
 Coding: _____ Other: _____

Current Health 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: _____ Birthdate: _____

Please make notations as related to the area(s) for which this study is being performed.

Please Show areas of :

Main Pain



Secondary Pain



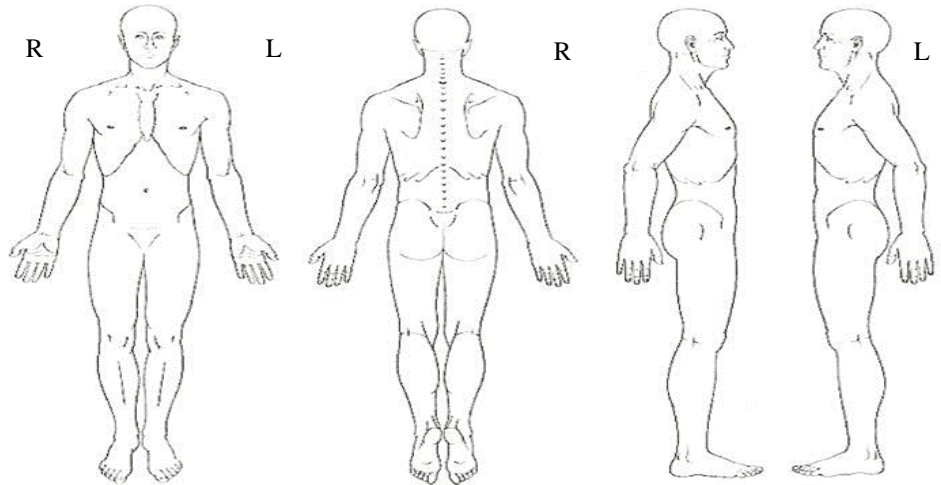
Numbness



Pins and needles



Skin lesions / scaring/ piercing



Health History: Check (✓) conditions you have or have had in the past

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Head Region:
<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Cataracts
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> TMJ - R / L
<input type="checkbox"/> Ear Infection
<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Other | <input type="checkbox"/> Vascular
<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Stroke
<input type="checkbox"/> Vascular Disorder
<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Other | <input type="checkbox"/> Muscular/Skeletal
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Carpel Tunnel
<input type="checkbox"/> Fracture
<input type="checkbox"/> Herniated Disk
<input type="checkbox"/> Joint Degeneration
<input type="checkbox"/> Nerve Damage
<input type="checkbox"/> Osteoporosis/penia
<input type="checkbox"/> Other | <input type="checkbox"/> Anemia
<input type="checkbox"/> Allergies
<input type="checkbox"/> Cancer/Tumors/Growths
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Fibromyalgia/CFS
<input type="checkbox"/> Gout
<input type="checkbox"/> Hernia
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Prosthesis
<input type="checkbox"/> Shingles
<input type="checkbox"/> Other _____

_____ |
| <input type="checkbox"/> Neck Region
<input type="checkbox"/> Thyroid (Hypo/Hyper)
<input type="checkbox"/> Carotid Arteries Narrow
<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Other | <input type="checkbox"/> Digestive Disorders
<input type="checkbox"/> Gastric Reflux
<input type="checkbox"/> Indigestion
<input type="checkbox"/> Irritable Bowel Syn
<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Polyps
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Colonoscopy
<input type="checkbox"/> Other | <input type="checkbox"/> Skin
<input type="checkbox"/> Acne
<input type="checkbox"/> Rash
<input type="checkbox"/> Other | <input type="checkbox"/> Female
<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Ovarian Fibroids
<input type="checkbox"/> Uterine Fibroids
<input type="checkbox"/> Vaginal Infection
<input type="checkbox"/> Other |
| <input type="checkbox"/> Lungs
<input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis/Pneumonia
<input type="checkbox"/> COPD/Emphysema
<input type="checkbox"/> Cold/Flu
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Other | <input type="checkbox"/> Other Organs
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Other | <input type="checkbox"/> Males
<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Other | <input type="checkbox"/> Dental
Last Visit _____

Root Canals # _____
Extracted Teeth #: _____
Partials ___ Upper ___ Lower
Permanents ___ Y ___ N
Amalgams Removed? _____
Chew gum regularly? _____ |

Primary reason(s) for having a Thermography Scan:

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 bus 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: _____ Date: _____

Name: _____

Birth date: _____

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

Breast Thermography Confidential Questionnaire

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you have any close relative who has had breast cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been diagnosed with breast cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been diagnosed with any other breast disease (fibrocystic)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any biopsies or surgeries to your breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had any breast cosmetic surgery or implants? _____ Date | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had a mammogram in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a mammogram in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had abnormal results from any breast testing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever taken a contraceptive pill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you suffered with cancer of the womb? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had pharmaceutical hormone replacement therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have an annual physical examination by a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you perform a monthly breast self exam? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? <input type="checkbox"/> Y <input type="checkbox"/> N Or finish after the age of 50? <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| 18. Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Not in last 12 months <input type="checkbox"/> Not in last 5 years | | |
| Began age _____ For # Years _____ Smoked # cig/cigars per day/wk _____ | | |

Have you recently had any of these breast symptoms:	Right Breast	Left Breast
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Change in breast size	<input type="checkbox"/>	<input type="checkbox"/>
Areas of skin thickening or dimpling	<input type="checkbox"/>	<input type="checkbox"/>
Secretions of the nipple	<input type="checkbox"/>	<input type="checkbox"/>

Diagnosed with Breast Cancer:

Key: UO = Upper Outer UI = Upper Inner LO = Lower Outer LI = Lower Inner

Cancer types: 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 conditions: (please report other types of disease in the history)

Disease types: Fibrocystic _____ Cystic _____ Mastitis _____ Abscess _____ Other _____

Breast biopsies or surgery: (Please list dates and any known results)

Where (left breast): UO _____ UI _____ LO _____ LI _____ Nipple _____
Where (right breast): UO _____ UI _____ LO _____ LI _____ Nipple _____
When: _____

Authorization to Use or Disclose Protected Health Information

Advanced Thermal Imaging

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, Advanced Thermal Imaging 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: **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 of Patient or Patient's Authorized Representative

Date

Authorized Signature of Facility

Date