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 a complete address, reports will be mailed to the patient for submission to their provider.*****)**

Current Medications	Altern. Therapies	Surgeries/Dates	Location of scars/tattoo's
	Nutritional Supplements		
	Chiropractic / DO		
	Acupuncture / Massage		
	Reiki / PT / Exercise		
	Other		

Fractures/Injuries:

____

____

Smoking Hx:
Do you smoke? ___Never ___Yes ___ 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. 052317 IM _____ C_____ DRP _____ A ________________________
Scan Type:________________________ Location: ____________________________/__________________________
Coding:

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 :

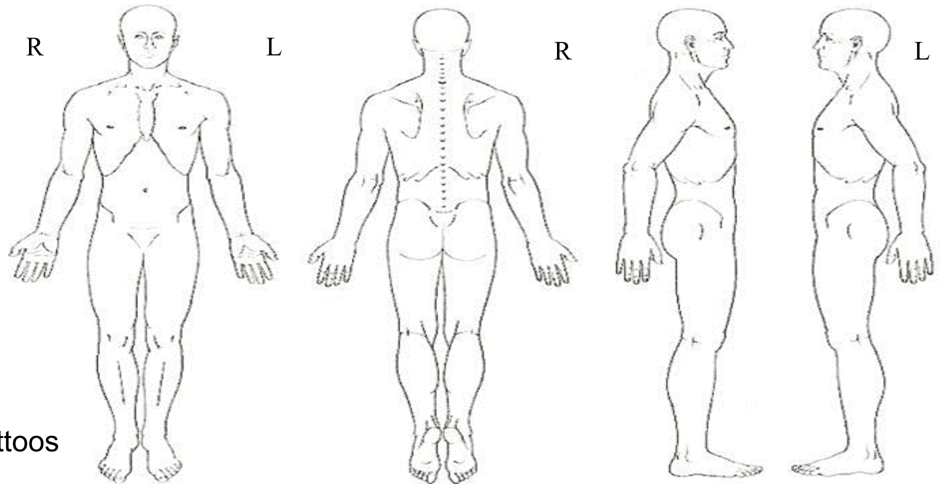
Main Pain *

Secondary Pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions / scaring / piercing / tattoos



Health History: Note "C" for current conditions or "P" for those in the past

□ Head Region:
___ Migraine Headaches
___ Sinus Problems
___ Cataracts
___ Glaucoma
___ TMJ - R / L
___ Ear Infection
___ Hearing Loss
___ Tinnitus
___ Other

□ Neck Region
___ Thyroid (Hypo/Hyper)
___ Carotid Arteries Narrow
___ Sore Throat (on scan date)
___ Other

□ Lungs
___ Asthma
___ Bronchitis
___ Pneumonia
___ COPD/Emphysema
___ Cold/Flu (on scan date)
___ Emphysema
___ Tuberculosis
___ Other

□ Vascular
___ Blood Clots
___ Heart Disease
___ High Blood Pressure
___ High Cholesterol
___ Pacemaker
___ Poor Circulation
___ Stroke
___ Vascular Disorder
___ Varicose Veins
___ Other

□ Digestive Disorders
___ Gastric Reflux
___ Indigestion
___ Irritable Bowel Syn
___ Diverticulitis
___ Polyps
___ Ulcers
___ Frequent Urination
___ Colonoscopy
___ Other

□ Skin
___ Acne (on scan date)
___ Rash (on scan date)
____
___ Other

□ Other Organs
___ Adrenal Stress
___ Kidney Disease
___ Liver Disease
___ Hepatitis
___ Other

□ Muscular/Skeletal
___ Arthritis
___ Carpel Tunnel R or L
___ Herniated Disk
___ Joint Degeneration
___ Nerve Damage
___ Osteoporosis/penia
___ Other

□ Female
___ Hot Flashes
___ Hysterectomy
___ Ovarian Fibroids
___ Uterine Fibroids
___ Vaginal Infection
___ Other

□ Males
___ Prostate Problem
___ Vasectomy
___ Other

___ Anemia
___ Allergies
___ Cancer/Tumors/Growths
___ Diabetes
___ Epilepsy
___ Fibromyalgia/CFS
___ Gout
___ Hernia
___ Multiple Sclerosis
___ Parkinson's Disease
___ Prosthesis
___ Shingles
___ Other ______________
____
____

□ Dental
Last Visit________________
Purpose:
____

Root Canals # _____
Extracted Teeth: _________
Partials ___Upper __ Lower
Permanents ___ Y ___ N
Amalgams Removed? _____
Chew gum regularly? _____
Braces (age)? ___________

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

	Question	Yes	No
1.	Do you have any close relative who has had breast cancer?	☐	☐
2.	Have you ever been diagnosed with breast cancer?	☐	☐
3.	Have you ever been diagnosed with any other breast disease (fibrocystic)?...........	☐	☐
4.	Have you had any biopsies or surgeries to your breasts?	☐	☐
5.	Have you had any breast cosmetic surgery or implants? _________ Date	☐	☐
6.	Have you had a mammogram in the past 12 months?	☐	☐
7.	Have you had a mammogram in the past 5 years?	☐	☐
8.	Have you had abnormal results from any breast testing?	☐	☐
9.	Have you ever taken a contraceptive pill? ……………………………………...	☐	☐
10.	Have you suffered with cancer of the womb?	☐	☐
11.	Have you had pharmaceutical hormone replacement therapy?	☐	☐
12.	Do you have an annual physical examination by a doctor?	☐	☐
13.	Do you perform a monthly breast self exam? ……………………………………..	☐	☐
14.	Did your periods start before the age of 12?	☐	☐
15	Did your periods finish after age 50?	☐	☐

16. How many mammograms have you had in total? _____
17. What was your age when you had your first mammogram? _____
18. How many births have you had? _____ Your age at birth of first child: _____ # Breast Fed: _____
19. Do you smoke? ☐ Yes ☐ Never ☐ Not in last 12 months ☐ 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	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

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 Full Legal Name: ____

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 : **Electronic Medical Interpretations (EMI)**

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**
For the specific purpose of: **Interpretation of said images**

In addition, I also hereby authorize this office and any of its employees to use or disclose my **Thermal Images and related health history** to the following person(s), entity(s), or business associates for the specific purpose of **continuity in health care and/or insurance medical review for claim & reimbursement** *(please print clearly and provide complete addresses if information is to be mailed):*

Family Member ____Relationship:_________________

Family Member ____Relationship:_________________

Guardian / Other ____Relationship:_________________

Health Care Provider ____

Insurance Company ____

If additional space is needed, please attach a separate page to this authorization and include your signature & date on the separate page(s).

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

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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