

Preparation Instructions for Chest Thermography

Thermography is infrared photography that reads heat emissions.
NO PAIN, NO RADIATION, NO CONTACT

Your body must be as neutral as possible to insure valid results.

NOTIFY the staff if you had any laser treatment (tattoos), surgery, chemotherapy, radiation or any other specialized therapies in the past 3 months, we may need to adjust your appointment for optimal results. Do you have any physical limitations or disabilities (sitting, standing raising your arms or legs)?

5 days before	NO natural or artificial tanning of any areas to be imaged. Sunburn of the underarms, front of neck, chest or breast area could interfere with the exam results. Allow to heal for at least 1-2 weeks.
24 hours before	If you get a significant fever (over 101°F), please call to reschedule.
	DO NOT shave areas to be imaged within 24 hours (under arms-etc.). DO NOT use a sauna, jacuzzi or steam-room. DO NOT use hot/cold packs directly contacting the breasts.
	NO self or clinical breast examinations (no squeezing). NO acupuncture, chiropractic or physical therapy. NO physical manipulation or compression of any areas to be examined. NO ultrasound therapy or use of tens (electrical stimulation). NO ultrasound, x-ray, mammograms, MRI, CT or PET scans.

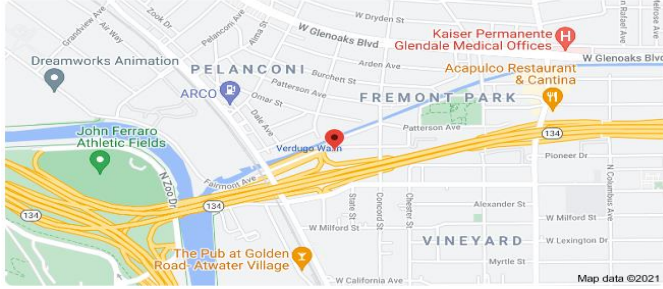
On the Day of Your Appointment

NO powders or make-up on your neck, chest or underarms. NO deodorants, skin creams, lotions, or perfumes. WEAR loose fitting garments on the day of your exam. REMOVE all jewelry and or piercings specific to areas being imaged.	
6 hours before exam	NO energy drinks or bars. NO pain medications or aspirin. NOTIFY the staff if you have taken medications (blood pressure, alpha-blocker, circulation, anti-coagulants, aspirin or pain medication). CHECK with your doctor if changes to your schedule can be made.
2-3 hours before exam	DO NOT shower, bathe, exercise, swim in the sun or heated pool less than 3 hours before your exam. NO food or beverages (room temperature water only). NO smoking, vaping, chewing tobacco, chewing gum, mints or candies.

We Look Forward to Seeing You and Providing Your Thermography Services!

Please arrive early, allow extra time for traffic delays or if you need to complete your paperwork at the office. Call the office where you scheduled your appointment at least 24 hours in advance for any appointment changes to avoid a missed appointment fee of **\$59 per instance. Check your email or text messages to contact your technician in case of a delay or an emergency**

Thermography Wellness Center 323-662-2891
770 Fairmont Ave #102, Glendale, CA 91203



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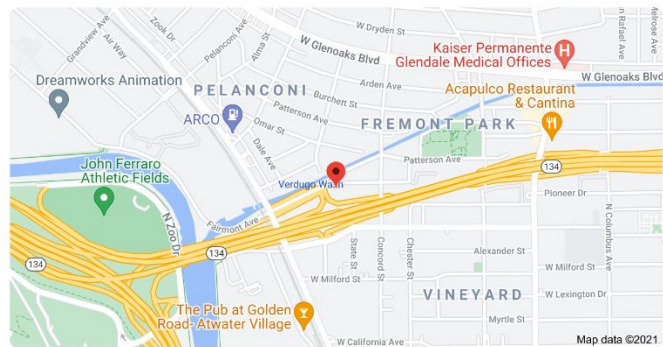
Thermography Wellness Center 619-269-8360
2802 Juan St. Ste 24A San Diego CA 92110



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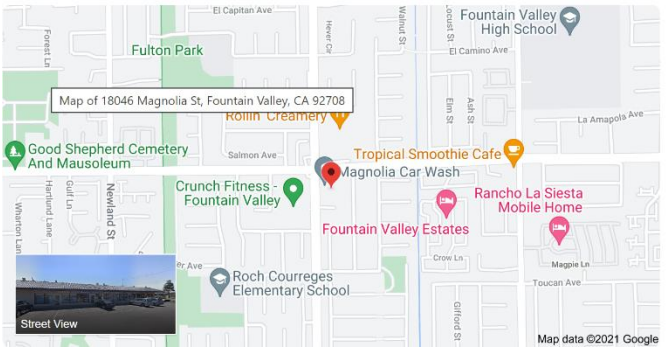
Mobile Locations

DeMoss Chiropractic 949-250-0600
20321 SW Birch Street, St.100 Newport Beach, CA 92660



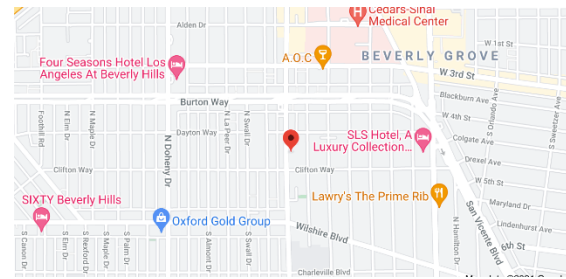
<https://goo.gl/maps/fKnfKA6f384vMWS7>

Bennett Acupuncture 714-962-5031
18046 Magnolia Avenue, Fountain Valley, CA 92708



<https://g.page/BennettAcupuncture?share>

Chiro Life Family Wellness 310-295-0253
250 N. Robertson Blvd Ste. 402, Beverly Hills, CA 90211



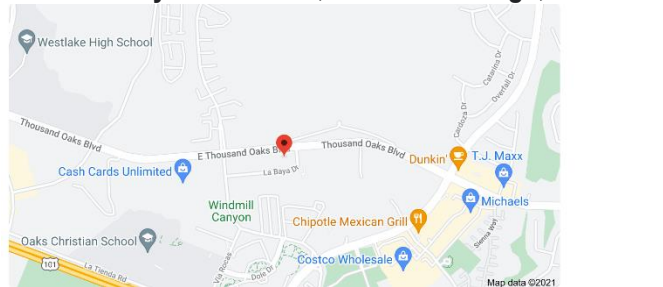
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Back To Health Chiropractic 661-250-1517
26505 Carl Boyer Dr, Santa Clarita, CA 91350



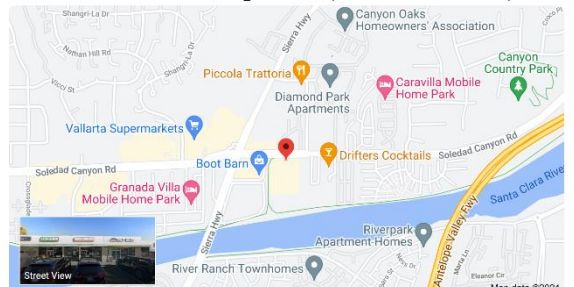
<https://goo.gl/maps/G129hgizGGhUxLta8>

Revive Family Health 818-851-9008
31225 La Baya Dr Ste 202, Westlake Village, CA 91362



<https://g.page/WestlakeVillageChiropracto?share>

New Life Chiropractic and Wellness 661-298-2700
18352 Soledad Canyon Rd, Santa Clarita, CA 91387



<https://goo.gl/maps/2fEJRZ2oY3BW5vCa9>



Thermography Wellness Center

Health History (Chest)

Patient Name: _____ **Appointment Date:** _____
Nickname: _____ **Home Phone:** _____
Address: _____ **Cell Phone:** _____
City/State/Zip: _____ / _____ / _____ **Carrier (text alert)** Att• TMbl • Vzn • _____
Gender Female _____ Male _____ **Email:** _____
Date of Birth: _____ **Age:** _____ **Referred By:** _____
Language: _____ **Primary Doctor:** _____ (DC,DO, MD)
Race: _____ **Occupation:** _____

OFFICE USE:				<input type="checkbox"/> EMAIL REPORT	<input type="checkbox"/> PAPER REPORT	[BB] [BS] [HFT] [GC] [PC]	
	NEW	3-6-9-12	1yr 3+yr	HOT	<input type="checkbox"/> Email + Audio	<input type="checkbox"/> Paper Copy \$35	
	J F M A M J J A S O N D				<input type="checkbox"/> Email Copy \$35	<input type="checkbox"/> RUSH	
	Mon	Wed	Fri		<input type="checkbox"/> Ph Consult -20	<input type="checkbox"/> Audio +\$35/rgn	
					FYI:	TOTAL \$	

HISTORY: R/L = Right/Left n/a = normal/abnormal (please circle what applies)						Technicians Notes:		
<input type="checkbox"/> None	Mammogram	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	
<input type="checkbox"/> No updates	Mammogram - 3D	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	
	R/L Breast Ultrasound	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	
	R/L Breast Biopsy <input type="checkbox"/> marker	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	
	R/L Breast Sonogram	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	
	Breast MRI	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	
	Breast CT	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	
	Breast PET	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	
	Blood Test – Cancer Markers _____	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	
	Salvia Test – Hormones _____	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	
		mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	<input type="checkbox"/> reports provided

PROCEDURES: R/L = Right/Left (please circle what applies)					
<input type="checkbox"/> None	R/L Implants - silicone	mo/yr: ___/___	R/L Reduction		mo/yr: ___/___
<input type="checkbox"/> No updates	R/L Implants - saline	mo/yr: ___/___	R/L Repair		mo/yr: ___/___
	R/L Lift	mo/yr: ___/___	R/L Implants Removed		mo/yr: ___/___
	R/L Reconstruction	mo/yr: ___/___	R/L		mo/yr: ___/___
				<input type="checkbox"/> reports provided	

DIAGNOSIS/CONDITIONS: R/L = Right/Left (please circle what applies)					
<input type="checkbox"/> None	R/L Abscess	mo/yr: ___/___	R/L Fibro adenoma		mo/yr: ___/___
<input type="checkbox"/> No updates	R/L Calcifications	mo/yr: ___/___	R/L Padget Disease		mo/yr: ___/___
	R/L Cystic/ Fibrocystic	mo/yr: ___/___	R/L Scar Tissue		mo/yr: ___/___
	R/L Dense Tissue	mo/yr: ___/___	R/L Toxicity Syndrome		mo/yr: ___/___
	R/L	mo/yr: ___/___	R/L		mo/yr: ___/___
	R/L Estrogen+/Progesterone+	mo/yr: ___/___			
	R/L HER2 positive Breast Cancer	mo/yr: ___/___			
	R/L IBC Inflammatory Breast Cancer	mo/yr: ___/___			
	R/L Ductal Carcinoma or Ductal Carcinoma In Situ	mo/yr: ___/___			
	R/L Lobular Carcinoma or Ductal Carcinoma In Situ	mo/yr: ___/___			
	R/L Metastatic Breast Cancer	mo/yr: ___/___			
	R/L Papillary Carcinoma	mo/yr: ___/___			
	R/L Triple Negative Breast Cancer	mo/yr: ___/___			
	R/L	mo/yr: ___/___			
	R/L	mo/yr: ___/___			
	R/L	mo/yr: ___/___			
				<input type="checkbox"/> reports provided	

Patient Name: _____

Date: _____

CANCER TREATMENT/SURGERIES: R/L = Right/Left (please circle what applies)					Technicians Notes:
<input type="checkbox"/> No updates	R/L Natural Salve	mo/yr: ___/___	Iodine Therapy	mo/yr: ___/___	
	R/L Ductal Lavage	mo/yr: ___/___	Immune Therapy	mo/yr: ___/___	
	R/L Laser	mo/yr: ___/___	Oxygen Therapy	mo/yr: ___/___	
	R/L Lumpectomy	mo/yr: ___/___	Nutrition/Supplements	mo/yr: ___/___	
	R/L Mastectomy	mo/yr: ___/___	Chemotherapy	mo/yr: ___/___	
	R/L Proton Radiation	mo/yr: ___/___	Hormone Drugs	mo/yr: ___/___	
	R/L Radiation	mo/yr: ___/___	Clinical Trial Drugs	mo/yr: ___/___	
	R/L	mo/yr: ___/___		mo/yr: ___/___	
Please explain:					<input type="checkbox"/> reports provided

FAMILY HISTORY: Breast cancer in family? (please circle what applies)						HER2+ BRCA1 BRCA2
<input type="checkbox"/> None	Familial: Mother	Father	Sister	Brother	<input type="checkbox"/>	
<input type="checkbox"/> Unknown	Maternal: Grandmother	Grandfather	Aunt	Uncle	Cousin	
<input type="checkbox"/> No updates	Paternal: Grandmother	Grandfather	Aunt	Uncle	Cousin	
						<input type="checkbox"/> reports provided

HORMONE REPLACEMENT: S/B/H =Synthetic Bio-Identical Herbs/Supplements (please circle)					
<input type="checkbox"/> None	S/B/H Estrogen	S/B/H Progesterone	S/B/H Testosterone	S/B/H Thyroid	
<input type="checkbox"/> No updates	S/B/H		S/B/H		
					<input type="checkbox"/> reports provided

HORMONE REPLACEMENT: S/B/H =Synthetic Bio-Identical Herbs/Supplements (please circle)					
<input type="checkbox"/> None	S/B/H Thyroid	S/B/H Estrogen	S/B/H Progesterone	S/B/H Testosterone	
<input type="checkbox"/> No updates	S/B/H		S/B/H		
					<input type="checkbox"/> reports provided

MEN: (please circle what applies)					
<input type="checkbox"/> None	Adrenal Fatigue	Age: _____	Hypothyroidism	Age: _____	
<input type="checkbox"/> No updates	Andropause	Age: _____	Low Libido	Age: _____	
	Erectile dysfunction	Age: _____	Night Sweats	Age: _____	
	Hyperthyroidism	Age: _____		Age: _____	
					<input type="checkbox"/> reports provided

BIRTH CONTROL: C/P = Currently Using /Previously Used (please circle what applies)					
<input type="checkbox"/> None	C/P Condoms	C/P Pill	C/P Spermicide	C/P Vasectomy	
<input type="checkbox"/> No updates	C/P Injection	C/P Natural Planning	C/P Sterilization	C/P Withdrawal	
	C/P		C/P		
					<input type="checkbox"/> reports provided

MEDICATIONS:		
<input type="checkbox"/> None	_____	
<input type="checkbox"/> No updates	_____	
		<input type="checkbox"/> reports provided

SUPPLEMENTS/HERBS:		
<input type="checkbox"/> None	Multi-Vitamins; A, B, B-12, C, D, E, K _____	
<input type="checkbox"/> No updates	_____	
		<input type="checkbox"/> reports provided

Patient Name: _____

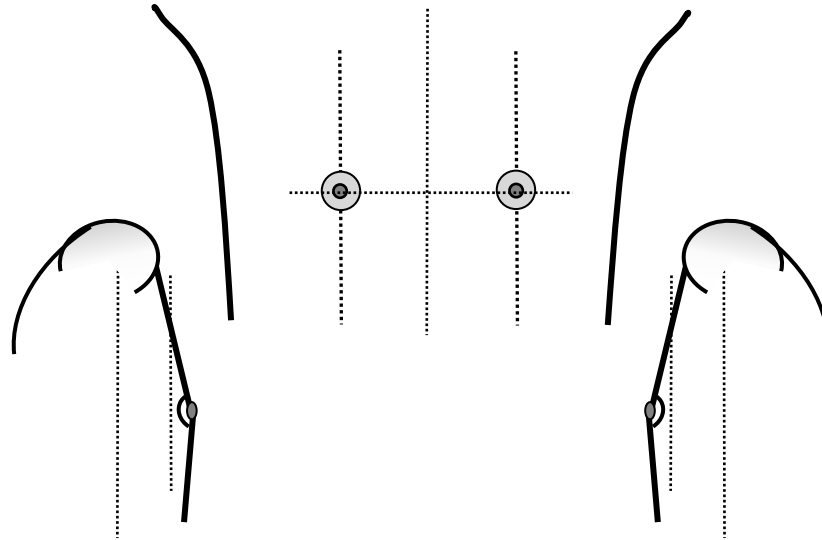
Date: _____

DIAGRAM condition and symptoms by the item #, using a dot, cross, circle arrow, etc.
Please indicate when or how long symptom/condition has existed.
NOTE the symptom/condition box, with a letter code for the frequency, using the following:
to indicate frequency "X"; A=Always F=Frequent I=Intermittent O=Occasional

RIGHT CHEST X

- Historically larger
- NO CONDITIONS

- 1 Bruising
- 2 Infection
- 3 Itching
- 4 Injury
- 5 Lump
- 6 Lump with pain
- 7 Marker
- 8 Nipple-tender
- 9 Nipple-inverted
- 10 Pain dull
- 11 Pain sharp
- 12 Pressure
- 13 Prickling
- 14 Rash
- 15 Scar Tissue
- 16 Skin-dimpling
- 17 Skin-discolored
- 18 Skin-scaly
- 19 Skin-reddening
- 20 Swollen
- 21 Tenderness
- 22 Piercing(s)
- 23 Tattoo(s)
- 24 Nipple-discharge [clear] [yellow] [brown] [bloody]
- 26 Breast size recently changed: [smaller] [larger]
- 27



LEFT BREAST X

- Historically larger
- NO CONDITIONS

- 1 Bruising
- 2 Infection
- 3 Itching
- 4 Injury
- 5 Lump
- 6 Lump with pain
- 7 Marker
- 8 Nipple-tender
- 9 Nipple-inverted
- 10 Pain dull
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- 21 Tenderness
- 22 Piercing(s)
- 23 Tattoo(s)
- 24 Nipple-discharge [clear] [yellow] [brown] [bloody]
- 26 Breast size recently changed: [smaller] [larger]
- 27

Please explain (how long and duration)

Technicians Notes:

INJURIES: Any breast/chest injuries throughout your life? (please circle what applies)

None R/L Auto Accident mo/yr: ___/___ R/L Parenting mo/yr: ___/___

No changes R/L Chemical Exposure mo/yr: ___/___ R/L Sports/Hobbies mo/yr: ___/___

R/L Occupational mo/yr: ___/___ R/L mo/yr: ___/___

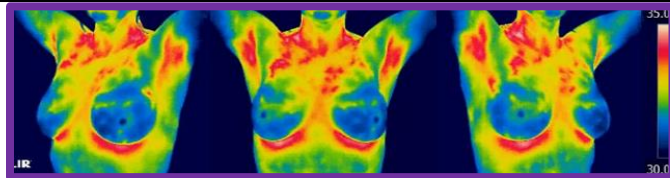
OFFICE USE:	VITALS	NOTES:
Board Certified Clinical Thermologist Dr. Claire H. O'Neill DC, FICCT, BCCT, DCTS I CTT:	BP (normal)	
	Pulse Resp.	
	Ht. °F	
	Wt. / °C	

01-TWC - PREP_Health History (Chest) AUG 2020.Docx

Thermography Wellness Center

Infrared breast thermography is non-invasive; no radiation, no injections, and no compression.

Other diagnostic equipment only detects a mass, but Thermography screens for cancer growth through changes in temperatures, thermal and vascular patterns. We use the "Breast Stress Study" system which catches these physiological changes and indicators that can be highly accurate. ... peace of mind through safe and early detection.



WHAT IS THERMOGRAPHY? ... it's the best way to follow your breast health! Infrared thermography is exceptional in catching breast cancer within the first year of development, as well as detecting and recording more advanced stages of breast malignancy. Infrared thermal imaging shows subtle and dramatic temperature differences along with thermal and vascular patterns that correlate with various types of Breast Pathology. Thermography is of great value in monitoring your Breast Health.

Please tell your families and friends of this 'Life Saving Technology'! It is safe for all ages; Men, Women, young teens, breast cancer patients, survivors, pregnant-nursing mothers, and breast implant recipients.

HIPPA Notice of Privacy Practices

How We Collect Information About You: Thermography Wellness Center and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, the intake form and any medical information provided.

What We Do with Your Information: Your information is held in strictest confidence. We do not give out, disseminate any information about patients that confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Use Your Information: Information is only used to provide you with health services which may require communication between us, other health care providers and insurance providers necessary to: verify your medical information is accurate.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of TWC. We reserve the right to use non-identifying information about our clients (those who receive services or goods from us) for research, education, training, informational and marketing purposes. Clients will not be compensated for use of this information and identifying information (photos, address, phone numbers, contact information, last name, or uniquely identifiable names) will **NOT** be used.

You may specifically request that NO information be used whatsoever for research/information/marketing purposes, but you must identify any requested restrictions in writing below. We respect your right to privacy and assure you no identifying information or images will ever be publicly used.

TWC may use my non-identifying images for research, education, training, or informational purposes.

TWC may use my written, photo, video and/or audio testimonials for marketing purposes.

TWC may not use my non-identifying images for research, education, or informational purposes.

Clearly Print Your Name _____

Patient Signature _____

Date _____