

Preparation Instructions for 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. |

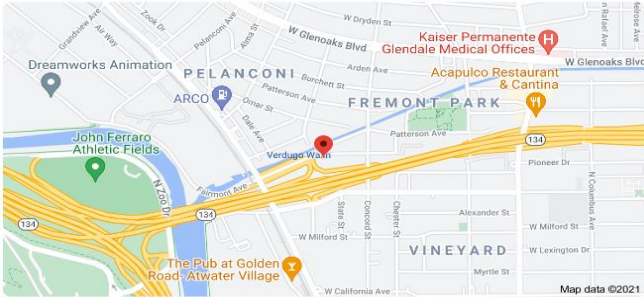
On the Day of Your Appointment

| | |
|---|--|
| NO powders on your breasts 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. IF NURSING , please complete 30 minutes before the exam, when possible. DO NOT BRING babies or children, as it will affect the outcome of your exam. | |
| 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



<https://goo.gl/maps/qEwVs2mc5TGZtm6n6>

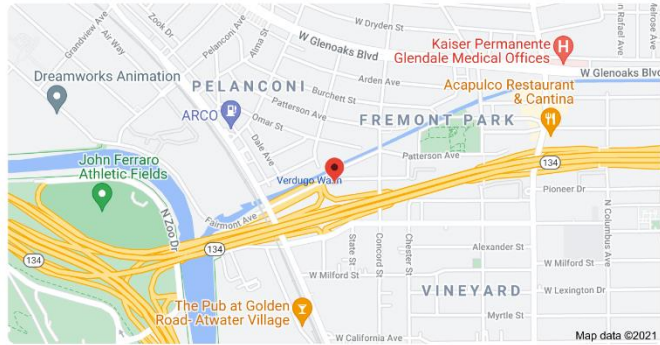
Thermography Wellness Center 619-269-8360
2802 Juan St. Ste 24A San Diego CA 92110



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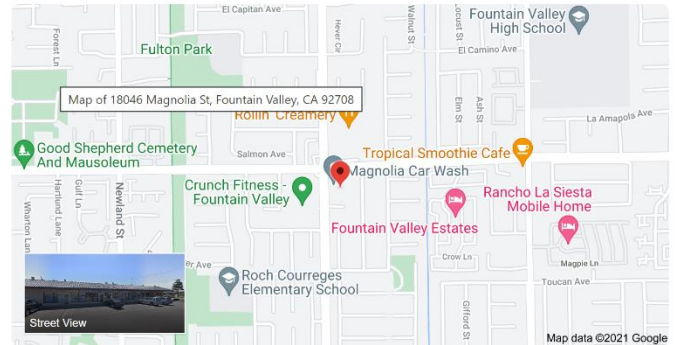
Mobile Locations

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



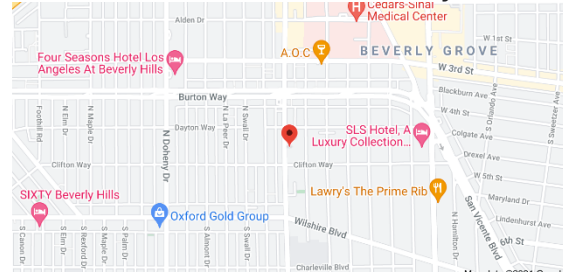
<https://goo.gl/maps/fKnfKA6f384vMWS7>

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



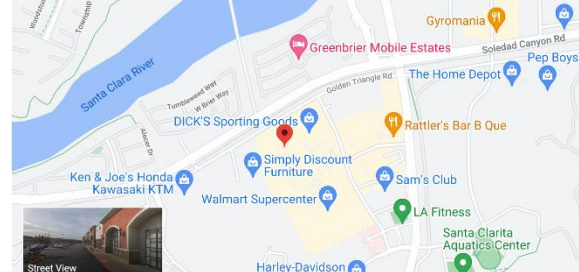
<https://g.page/BennettAcupuncture?share>

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 (Cephalic)

| | |
|---|---|
| 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 -20min | <input type="checkbox"/> Audio +\$35/rgn | |
| FYI: | | | | | TOTAL \$ | |

| | |
|---|---------------------------|
| HEALTH HISTORY (reason for your visit) | Technicians Notes: |
| Complaint/Concern: _____ | |
| Condition/Diagnosis: _____ | |

| |
|---------------------------|
| MEDICATIONS: _____ |
|---------------------------|

| |
|------------------------|
| ALLERGIES _____ |
|------------------------|

| |
|--|
| SUPPLMENTS: Multi-Vitamins A, B, B-12, C, D, E, K |
|--|

| |
|--|
| SURGERIES: Please list date, type, and location (left/right – anterior posterior) |
|--|

| |
|---|
| HOSPITALZTIONS Please list date, what for and length of stay |
|---|

| |
|-----------------------------------|
| MAJOR ILLNESS/INJURY _____ |
|-----------------------------------|

| |
|---|
| VACCINES/IMUNIZATIONS Please list date, type |
|---|

| |
|------------------|
| TESTS |
| Biopsy _____ |
| Blood _____ |
| CT _____ |
| MRI _____ |
| Ultrasound _____ |
| X-ray _____ |

| |
|---|
| PROVIDERS List providers and treatments: |
| _____ |
| _____ |

Patient Name: _____

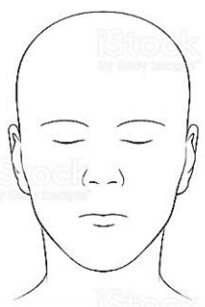
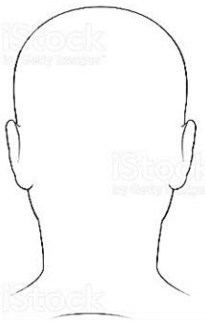
Date: _____

| FAMILY HISTORY: | | | | | Technicians Notes: |
|-----------------|-----------|--------|----------|---------------|--------------------|
| Maternal | Arthritis | Cancer | Diabetes | Heart Disease | |
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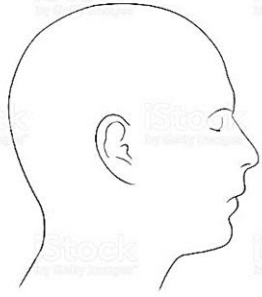
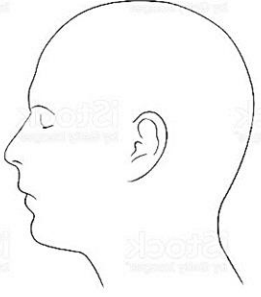
| SOCIAL HISTORY: | | |
|-----------------|---------|-------|
| Smoker | Alcohol | Drugs |

| OCCUPATIONAL HISTORY | List daily activities, ergonomic furniture, toxic exposure, etc. |
|----------------------|--|
| | |
| | |

| IMPLANT DEVICES |
|-----------------|
| |
| |

| SYMPTOMS | X | ANTERIOR | POSTERIOR | X | SYMPTOMS |
|---------------------|--------------------------|--|---|--------------------------|---------------------|
| 1 bleeding/bruising | <input type="checkbox"/> |  |  | <input type="checkbox"/> | 1 bleeding/bruising |
| 2 infection | <input type="checkbox"/> | | | <input type="checkbox"/> | 2 infection |
| 3 itching/rash | <input type="checkbox"/> | | | <input type="checkbox"/> | 3 itching/rash |
| 4 lump | <input type="checkbox"/> | | | <input type="checkbox"/> | 4 lump |
| 5 numbness | <input type="checkbox"/> | | | <input type="checkbox"/> | 5 numbness |
| 6 pain | <input type="checkbox"/> | | | <input type="checkbox"/> | 6 pain |
| 7 pressure | <input type="checkbox"/> | | | <input type="checkbox"/> | 7 pressure |
| 8 piercings(s) | <input type="checkbox"/> | | | <input type="checkbox"/> | 8 piercings(s) |
| 9 tattoo (s) | <input type="checkbox"/> | | | <input type="checkbox"/> | 9 tattoo (s) |
| 10 | <input type="checkbox"/> | | | <input type="checkbox"/> | 10 |
| 11 | <input type="checkbox"/> | | | <input type="checkbox"/> | 11 |

Please list symptoms, Indicate X = **F**requent, **I**ntermittent or **O**ccasional and mark/# on diagrams

| SYMPTOMS | X | RIGHT LATERAL | LEFT LATERAL | X | SYMPTOMS |
|---------------------|--------------------------|---|--|--------------------------|---------------------|
| 1 bleeding/bruising | <input type="checkbox"/> |  |  | <input type="checkbox"/> | 1 bleeding/bruising |
| 2 infection | <input type="checkbox"/> | | | <input type="checkbox"/> | 2 infection |
| 3 itching/rash | <input type="checkbox"/> | | | <input type="checkbox"/> | 3 itching/rash |
| 4 lump | <input type="checkbox"/> | | | <input type="checkbox"/> | 4 lump |
| 5 numbness | <input type="checkbox"/> | | | <input type="checkbox"/> | 5 numbness |
| 6 pain | <input type="checkbox"/> | | | <input type="checkbox"/> | 6 pain |
| 7 pressure | <input type="checkbox"/> | | | <input type="checkbox"/> | 7 pressure |
| 8 piercings(s) | <input type="checkbox"/> | | | <input type="checkbox"/> | 8 piercings(s) |
| 9 tattoo (s) | <input type="checkbox"/> | | | <input type="checkbox"/> | 9 tattoo (s) |
| 10 | <input type="checkbox"/> | | | <input type="checkbox"/> | 10 |
| 11 | <input type="checkbox"/> | | | <input type="checkbox"/> | 11 |

| Region | Please describe symptoms/conditions indicated, what makes it worse or better?: | Since/Dates |
|--------|--|-------------|
| | | () |
| | | () |
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| OFFICE USE: | VITALS | | NOTES: |
|--|--------|-----------|--------|
| Board Certified Clinical Thermologist Dr. Claire H. O'Neill DC, FICCT, BCCT, DCTSI CTT: | BP | (normal) | |
| | Pulse | Resp. | |
| | Ht. | °F | |
| | Wt. | / °C | |

Thermography Wellness Center

Infrared thermography is non-invasive, no radiation, no injections, and no compression. Thermography detects pathology through physiological changes and vascular patterns along with other significant protocols to make this process up to 97% accurate.

... peace of mind through safe and early detection.

WHAT IS THERMOGRAPHY? ... Infrared thermal imaging shows subtle and dramatic temperature difference along with thermal and vascular patterns that correlate with various types of Breast Pathology. Thermography is of great value in monitoring the effectiveness of thermal protocols.

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

HIPAA 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 no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will 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