

Preparation Guide - Men's Chest Thermography

Bring This Form With You - Do Not Email

**Infrared Thermography Measures Your Body's Radiant Heat Emission Patterns.
Your Body Must Be As Neutral As Possible To Ensure Valid Results.**

NOTIFY US if you have had any chemotherapy, laser treatments (tattoos), radiation, surgery or any other specialized procedures or therapies in the past three months, to reschedule your appointment.

5 days before	<u>AVOID</u> natural or artificial tanning of any areas to be imaged. Allow 1-2 weeks to heal sunburned areas.
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If You Get A Significant Fever (Over 101 °F) Please Call Us To Reschedule

24 hours before	<p><u>DO NOT</u> shave areas to be imaged within 24 hours.</p> <p><u>DO NOT</u> use a sauna, jacuzzi, infrared therapy or steam room.</p> <p><u>DO NOT</u> use hot/cold packs on the areas to be imaged.</p> <p><u>NO</u> bleaching, henna tattoos, massage or waxing of any areas to be imaged.</p> <p><u>NO</u> acupuncture, chiropractic, or physical therapy.</p> <p><u>NO</u> compression or physical manipulation of any areas to be examined.</p> <p><u>NO</u> ultrasound or tens therapy (electrical stimulation).</p> <p><u>NO</u> CT, MRI, PET scans, Ultrasound or X-rays.</p>
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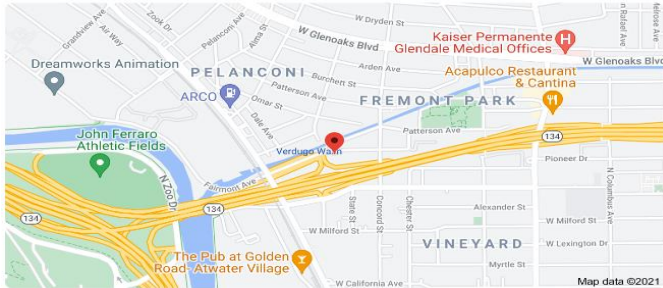
On The Day Of Your Appointment...

<p><u>NO</u> deodorant, colognes/perfumes, lotions, powders or skin cream.</p> <p><u>WEAR</u> loose-fitting garments on the day of your exam.</p> <p><u>REMOVE</u> jewelry and or piercings specific to the areas being imaged.</p> <p><u>DO NOT BRING</u> babies or children, as it will affect the outcome of your exam.</p>	
6 hours before	<p><u>NO</u> energy drinks or protein bars.</p> <p><u>AVOID</u> aspirin, balms or mild pain medications.</p> <p><u>NOTIFY</u> the staff if you have taken medications.</p>
2-3 hours before	<p><u>AVOID</u> exercise, hot bath/showers or swimming in the sun or heated pool.</p> <p><u>NO</u> beverages or food (room temperature water only).</p> <p><u>NO</u> candies, chewing gum, mints, smoking, vaping, or chewing tobacco.</p>

WE LOOK FORWARD TO PROVIDING YOUR THERMOGRAPHY SERVICER

Please Plan on arriving early or contact us as soon as you can in case of an emergency. Allow enough time for traffic delays and to complete your paperwork at the office. Call at least 24 hours in advance for any schedule changes to avoid a missed appointment fee of \$89.

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



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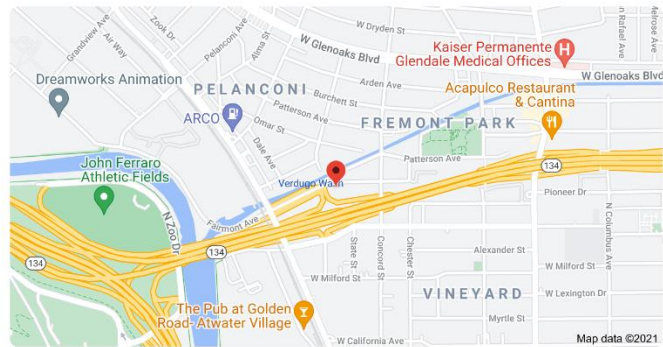
Thermography Wellness Center 619-269-8360
2802 Juan St. Ste 24A San Diego CA 92110



<https://goo.gl/maps/5JnGrEbst9bp1yNT8>

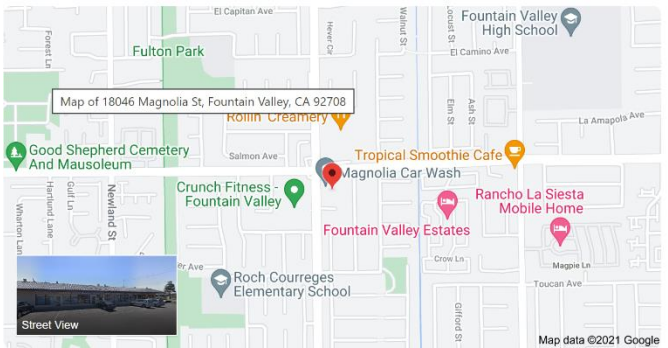
Mobile Locations

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



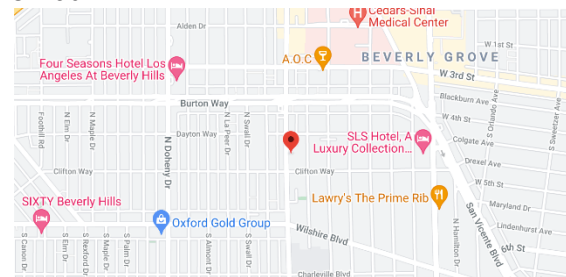
<https://goo.gl/maps/fKnfKA6f384vMWS7>

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



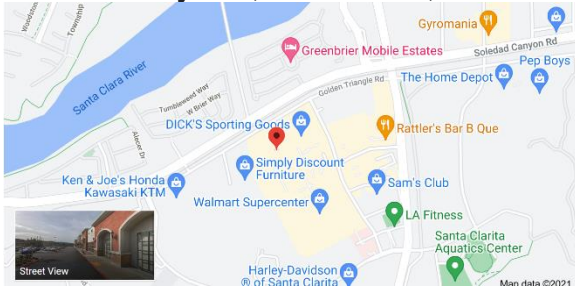
<https://g.page/BennettAcupuncture?share>

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



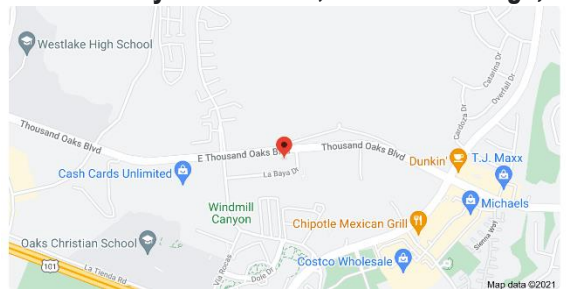
<https://goo.gl/maps/KE1spZmPu1aVJ5w6>

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



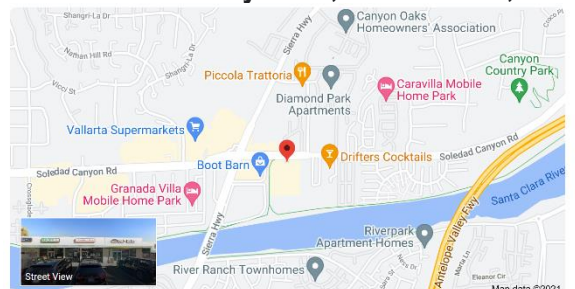
<https://goo.gl/maps/G129hgizGGhUxLta8>

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 (Men's 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)

	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a	mo/yr: ___/___	n/a
<input type="checkbox"/> None Mammogram	___/___	n/a	___/___	n/a	___/___	n/a
<input type="checkbox"/> No updates Mammogram - 3D	___/___	n/a	___/___	n/a	___/___	n/a
R/L Breast Ultrasound	___/___	n/a	___/___	n/a	___/___	n/a
R/L Breast Biopsy <input type="checkbox"/> marker	___/___	n/a	___/___	n/a	___/___	n/a
R/L Breast Sonogram	___/___	n/a	___/___	n/a	___/___	n/a
Breast MRI	___/___	n/a	___/___	n/a	___/___	n/a
Breast CT	___/___	n/a	___/___	n/a	___/___	n/a
Breast PET	___/___	n/a	___/___	n/a	___/___	n/a
Blood Test – Cancer Markers	___/___	n/a	___/___	n/a	___/___	n/a
Salvia Test – Hormones	___/___	n/a	___/___	n/a	___/___	n/a
	___/___	n/a	___/___	n/a	___/___	n/a

Technicians Notes:

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: ___/___

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 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 Lobular 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: ___/___		

reports provided

Patient Name: _____

Date: _____

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

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"/> reports provided
<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 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:				
<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	

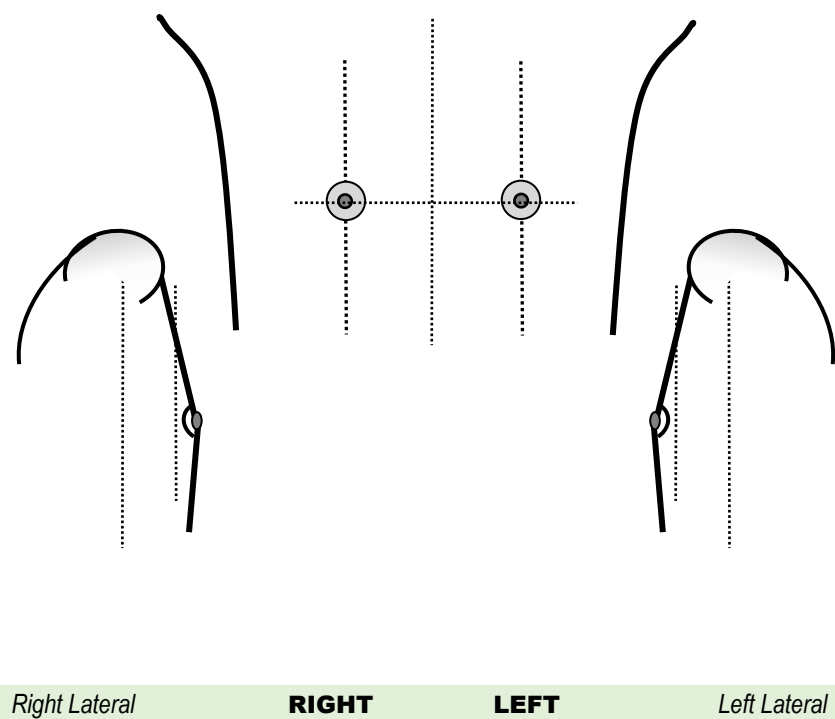
Patient Name: _____

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-fixed/movable
- 6 Lump-hard/soft
- 7 Lump with pain
- 8 Marker
- 9 Nipple-tender
- 10 Nipple-inverted
- 11 Pain dull
- 12 Pain sharp
- 13 Pressure
- 14 Prickling
- 15 Rash
- 16 Scar Tissue
- 17 Skin-dimpling
- 18 Skin-discolored
- 19 Skin-scaly
- 20 Skin-reddening
- 21 Swollen
- 22 Tenderness
- 23 **Piercing(s)**
- 24 **Tattoo(s)**
- 25 Nipple-discharge [clear] [yellow] [brown] [bloody]
- 26 Breast size recently changed: [smaller] [larger]
- 27



LEFT CHEST X

- Historically larger
- NO CONDITIONS
- 1 Bruising
- 2 Infection
- 3 Itching
- 4 Injury
- 5 Lump-fixed/movable
- 6 Lump-hard/soft
- 7 Lump with pain
- 8 Marker
- 9 Nipple-tender
- 10 Nipple-inverted
- 11 Pain dull
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- 16 Scar Tissue
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- 24 **Tattoo(s)**
- 25 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)

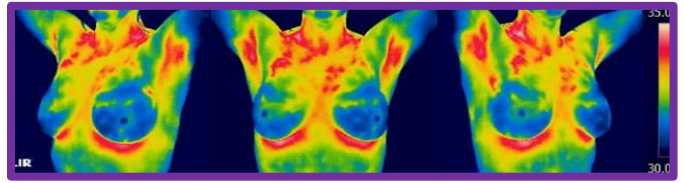
- None
- R/L Auto Accident mo/yr: ___/___
- R/L Chemical Exposure mo/yr: ___/___
- R/L Occupational mo/yr: ___/___
- R/L Parenting mo/yr: ___/___
- R/L Sports/Hobbies mo/yr: ___/___
- R/L Vaccines mo/yr: ___/___

OFFICE USE:	VITALS	NOTES:
Board Certified Clinical Thermologist Dr. Claire H. O'Neill DC, FICCT, BCCT, DCTS 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? ... 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 and conditions: Men, Women, Babies, 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 staff 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 is confidential, as restricted by law, or has been specifically restricted by a patient/client 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.

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. 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