Preparation Guide - Groin 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	**AVOID** natural or artificial tanning of any areas to be imaged. Allow 1-2 weeks to heal sunburned areas.

If You Get A Significant Fever (Over 101 °F) Please Call Us To Reschedule

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

On The Day Of Your Appointment...

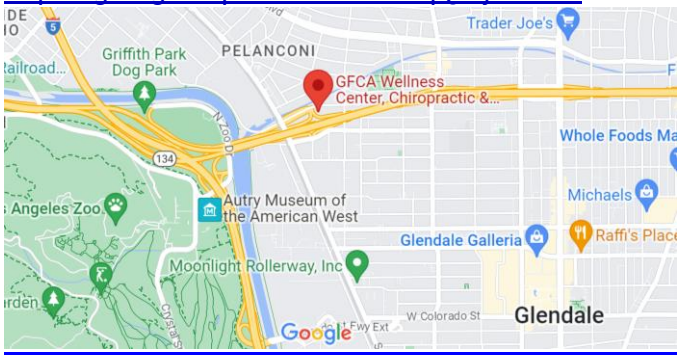
NO colognes/perfumes, lotions, powders or skin cream. **WEAR** loose-fitting garments on the day of your exam, no hats or head bands. **REMOVE** jewelry and or piercings specific to the areas being imaged. **DO NOT BRING** babies or children, as it will affect the outcome of your exam.	
6 hours before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

We Look Forward To Providing Your Thermography Servicer

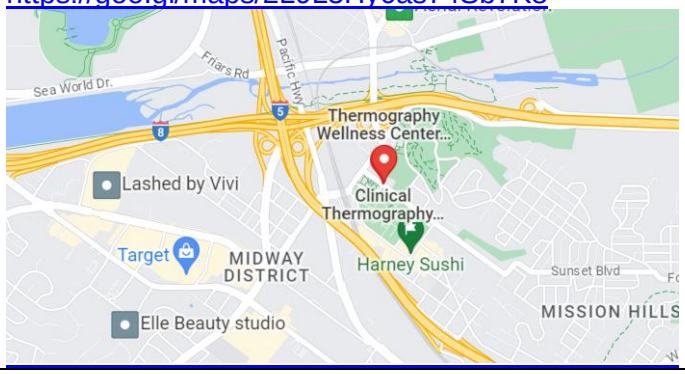
Please Plan on arriving early or contact us as soon as you can in case of an emergency. Allow enough time for traffic delays and to complete your paperwork at the office. Call at least 24 hours in advance for any schedule changes to avoid a missed appointment fee of $81.

Thermography Wellness Centers

Thermography Wellness Center 323.662.2891 833.484.3767
770 Fairmont Ave #102, Glendale, CA 91203
https://goo.gl/maps/VwCE5UmbqQmjkMFZ9

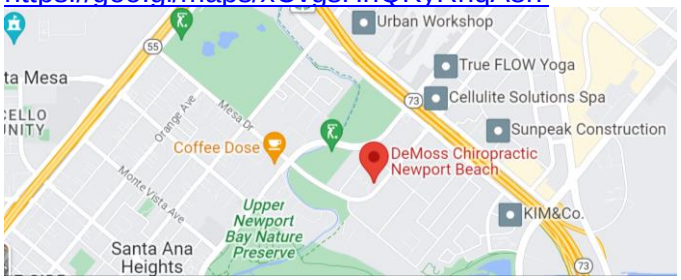


Thermography Wellness Center Old Town 619-269-8360
2802 Juan St. Ste 24A San Diego CA 92110
https://goo.gl/maps/2L9L3Hy6as74Sb7K8

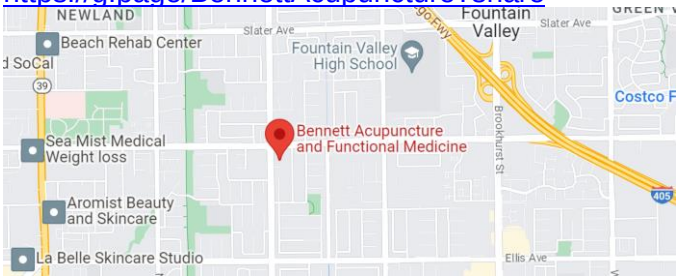


Mobile Locations

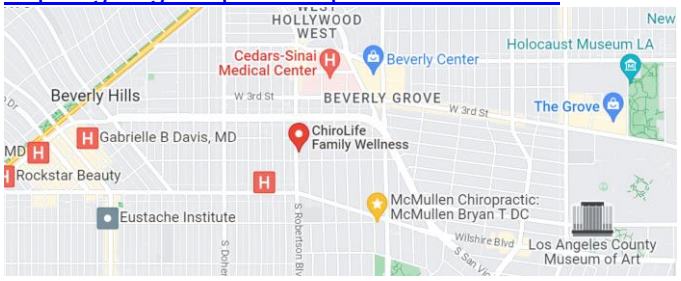
DeMoss Chiropractic 949-250-0600
20321 SW Birch Street, St.100 Newport Beach, CA 92660
https://goo.gl/maps/xCvgsHnQKyRhqA8i7



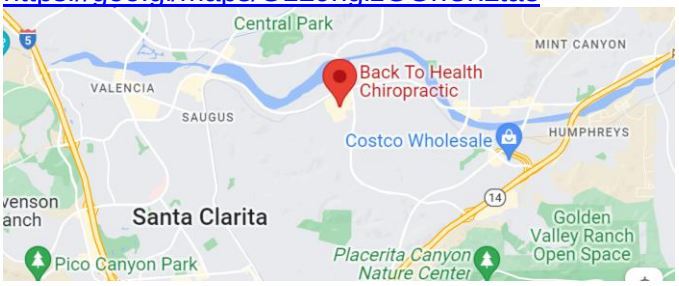
Bennett Acupuncture 714-962-5031
18046 Magnolia Avenue, Fountain Valley, CA 92708
https://g.page/BennettAcupuncture?share



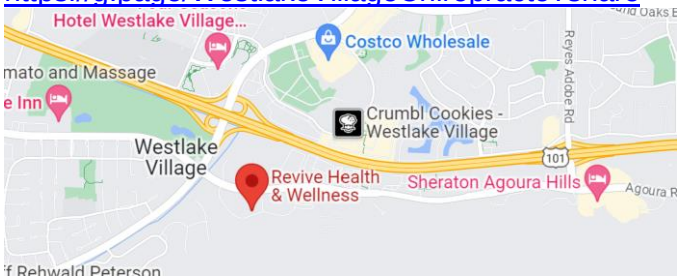
Chiro Life Family Wellness 310-295-0253
250 N. Robertson Blvd Ste. 402, Beverly Hills, CA 90211
https://goo.gl/maps/KE1spZzmPu1aVJ5w6



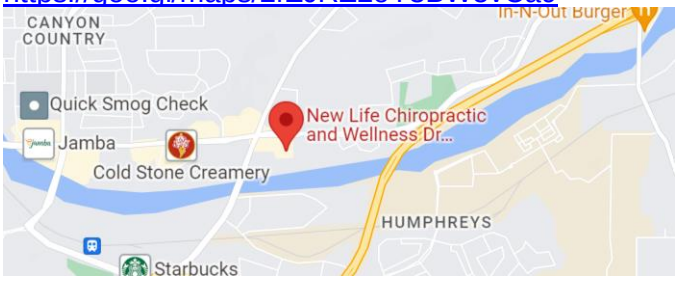
Back To Health Chiropractic 661-250-1517
26505 Carl Boyer Dr, Santa Clarita, CA 91350
https://goo.gl/maps/G129hgizGGhUxLta8



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 (Torso-Groin)

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, ND)*
Race:		**Occupation:**	

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

HEALTH HISTORY *(reason for your visit)*

Concerns:

Condition/Diagnosis:

Technicians Notes:

LABS/TESTS: *please list type, results/attach reports, month/year-this condition*

Biopsy, Bone Scan, EMG,
AMAS, Blood, PSA, Saliva
CT, MRI, Ultrasound, X-ray,
Thermography, Other

PROVIDERS/THERAPIES *please list type and last date treated for this condition:*

DC, Lac, ND
DO, MD

PROCEDURES: *please list reason and month/year if related to this condition*

Implants, Root Canal

HOSPITALIZATIONS /SURGERIES: *please list reason and month/year if related to condition*

ALLERGIES: *if related to this condition*

FAMILY HISTORY:

Maternal	Arthritis	Cancer	Diabetes	Heart Disease
Paternal	Arthritis	Cancer	Diabetes	Heart Disease

SOCIAL HISTORY: *smoker, alcohol, drugs, home environment*

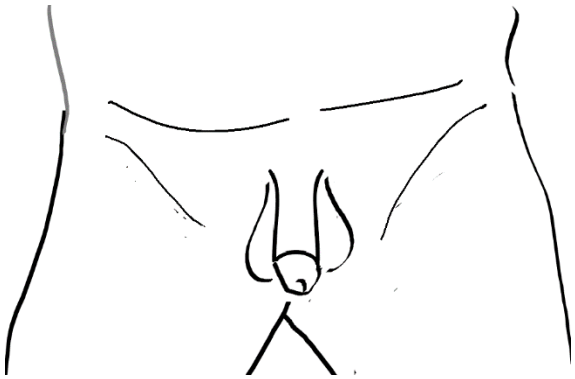
OCCPATONAL HISTORY *list daily activities, ergonomics,, etc.*

MEDICATIONS/HORMONES: *please include vaccinations-type/series, location and month/year*

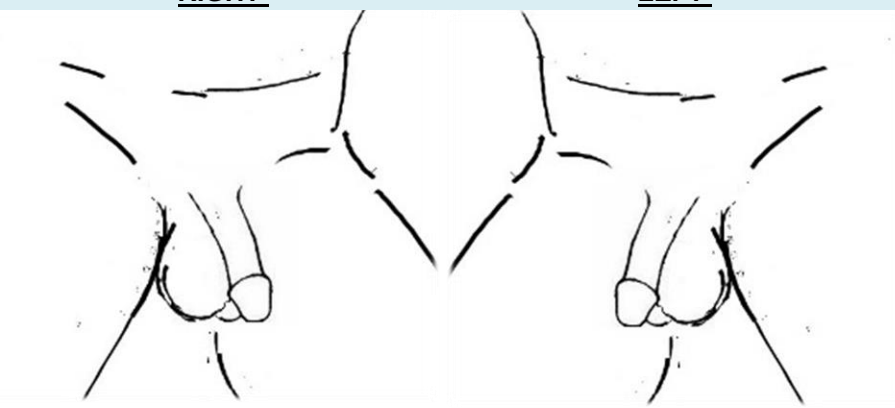
Technicians Notes:

SUPPLEMENTS: *multi-vitamins A, B, B-12, C, D, E, K*

Patient Name: _____ **Date:**_____

SYMPTOMS	X	ANTERIOR-GROIN	X	SYMPTOMS
1 bleeding/bruising				1 bleeding/bruising
2 infection				2 infection
3 itching/rash				3 itching/rash
4 lump				4 lump
5 numbness				5 numbness
6 pain				6 pain
7 pressure				7 pressure
8 piercings(s)				8 piercings(s)
9 tattoo (s)				9 tattoo (s)
10				10
11				11

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

SYMPTOMS	X	RIGHT LEFT	X	SYMPTOMS
1 bleeding/bruising				1 bleeding/bruising
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7 pressure				7 pressure
8 piercings(s)				8 piercings(s)
9 tattoo (s)				9 tattoo (s)
10				10
11				11

REGION	*describe symptoms/conditions and what makes it worse or better?:*	month/year
		( )
		( )
		( )
		( )
		( )
		( )

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** Vaccines mo/yr: ____/_____

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

Thermography Wellness Center

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

WHAT IS THERMOGRAPHY? … Infrared thermal imaging shows subtle and dramatic temperature imaging with thermal and vascular patterns that correlate with various types of pathology.

Medical/Chiropractic Thermography is a diagnostic tool that measures the body's radiant heat emission patterns. The thermal scan provides a visual "heat map" of infrared radiation (IR) in the electromagnetic spectrum from 2-14 μm band width. Thermography is not a picture of pain but demonstrates thermal and physiological changes in complex tissues that will result from pain syndrome.

Thermography provides physiological information (what is happening right now) as compared to X-ray, MRI, CT scans which provide anatomical information (where or why it happened). Thermography and interpretation adds a third dimension to the clinical picture

Infrared Breast Thermography is non-invasive, no radiation, no injections, and no compression. It is safe for all ages and conditions: Men, Women, Babies, Teens, Breast Cancer Patients, Survivors, Pregnant-Nursing Mothers, and Breast Implant Recipients.

Please tell your families and friends of this "Life Saving Technology"!

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