INFRARED THERMAL IMAGING - INTAKE FORM

1. IDENTIFICATION

DATE: _____ CLINIC: _____

NAME:_____

EMAIL:_____

CELL #: _____

SEX: [ ] Male [ ] Female

DATE OF BIRTH: _____ AGE: _____

CITY:_____STATE:_____ZIP:_____

2. REFERRING PRACTITIONER:

NAME: _____ PHONE: ( )

EMAIL:_____

3. EXAM PURPOSE

Main Complaint (indicate side: Right-R or Left-L): _____

Other Complaints (indicate side: Right-R or Left-L): _____

Suspected Diagnosis: _____ Start

Date of Main Complaint: _____

4. CLINICAL DATA

Current Pain Level (0 to 10): _____

Associated Conditions (check all that apply):

[ ] Diabetes [ ] Varicose Veins [ ] Thrombosis [ ] Heart Attack

[ ] Hypertension [ ] Heart Disease [ ] Stroke [ ] Hypothyroidism

[ ] Breast Tumor [ ] Gastritis [ ] Hepatitis [ ] Arthrosis

[ ] Arthritis (Positive Blood Test?) [ ] No [ ] Yes

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[ ] Old Fractures (Location: _____) [ ] Paralysis (Location: _____)
[ ] Kidney Stones [ ] Gallbladder Stones [ ] Endometriosis [ ] Polycystic Ovary

Allergies:
[ ] Respiratory (Asthma) [ ] Food [ ] Skin Contact
[ ] Acne [ ] Skin Lesions [ ] Sinusitis [ ] Rhinitis
[ ] Infections [ ] Cancer [ ] Fever

Specify: _____

Associated Symptoms:
[ ] Itching [ ] Sleep Problems [ ] Diarrhea [ ] Constipation
[ ] Dizziness [ ] Memory Loss [ ] Tingling ([ ] Hands [ ] Feet)
[ ] Ankle Swelling [ ] Bloating [ ] Gas [ ] Bleeding

Date of Last Menstruation: _____

Family History of Cancer (Type & Relation): _____

Other Family Conditions: _____

5. SURGICAL HISTORY

Check all surgeries:
[ ] Spine [ ] Heart [ ] Kidney [ ] Lung [ ] Joints [ ] Herniated Disc
[ ] Nerve Blocks [ ] C-section [ ] Gallbladder [ ] Thyroid [ ] Varicose Veins
[ ] Circulatory [ ] Cosmetic [ ] Eyes [ ] Appendix [ ] Ovary
[ ] Breasts [ ] Uterus [ ] Hiatal Hernia [ ] Obesity

Others (specify): _____

Scheduled Surgeries: _____

Proposed but Unperformed Surgeries: _____

Current Medications: _____

Hormone Use (Thyroid, Breast, Uterus, Ovary, Contraceptives): _____

6. EXAM RESULTS

Please copy final impressions and year of exams:

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X-ray: _____

Ultrasound: _____

Electroneuromyography: _____

CT Scan: _____

MRI: _____

Scintigraphy: _____

Densitometry: _____

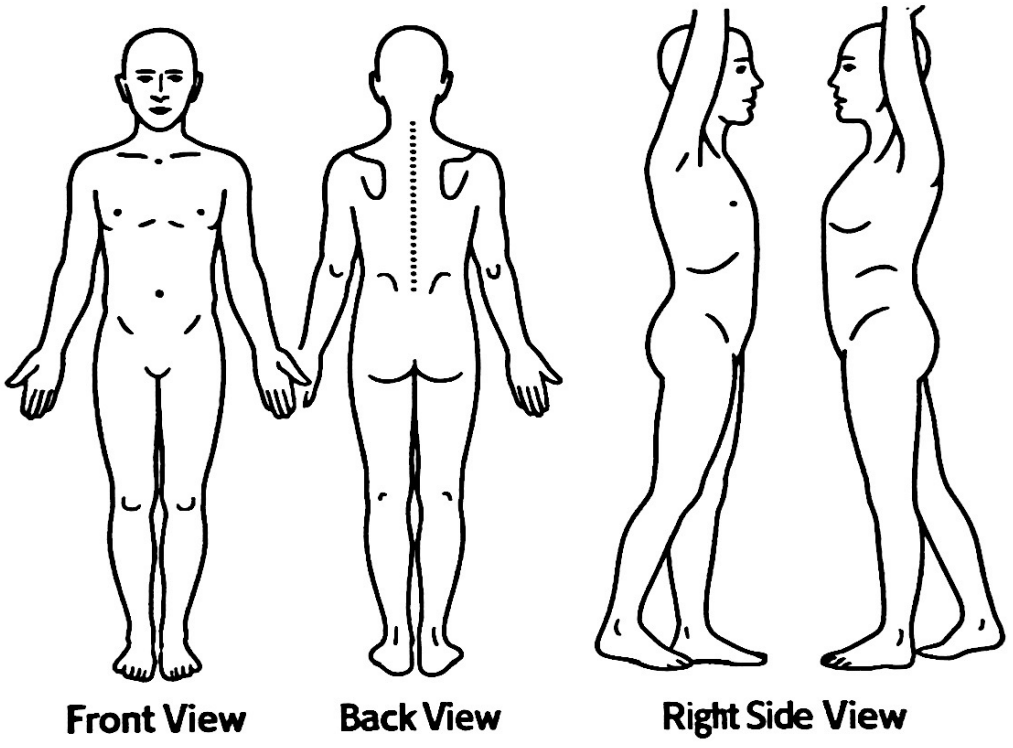
Endoscopy/Colonoscopy: _____

Infrared Imaging: _____

Mammography: _____

Other: _____

7. PAIN DIAGRAM



Pain intensity

INFORMED CONSENT FOR IMAGING
FULL-BODY and/or BREAST

Safe Body Imaging

Infrared thermal imaging is a technology which measures the surface temperature of the body using infrared cameras, and is analyzed to provide physiological information as a complimentary adjunct to other standard screening and diagnostic testing.

I understand that thermal imaging does not directly detect, or should be used to diagnose a specific disease.There is no stand alone screening test that can "diagnose" cancer, of which can only be diagnosed with a biopsy and pathologist. The information provided with infrared thermal imaging is designed to be used with other standard screening tests as an aid to determine a proper diagnosis by a medical professional. Also, thermography cannot rule out the presence of a disease, since some conditions do not produce sufficient temperature changes immediately on the surface of the body to be seen with thermography I also understand that an injury or a disease could still be present despite a lack of thermal findings presented at the time of imaging. All health concerns require evaluation by a medical professional regardless of the information provided in a thermography report. Infrared thermal imaging as a stand alone detection for screening is not suggested, as it is with any other standard medical screening test.

I also understand that not all organ systems and medical conditions will produce clear thermal findings that will enable thermal detection at the time of imaging. Therefore, I understand that thermography cannot determine or diagnose if an organ or the body is diseased or healthy. It is a functional test which can provide specific areas to be evaluated more thoroughly by a medical professional. It cannot replace or rule out the need for a complete medical examination or additional testing ordered by a medical professional.

I confirm that I have followed the written pre examination protocol for thermal imaging prior to my imaging appointment, of which is made public on the website under forms. I understand that if I did not review and follow the protocol provided, the accuracy of my examination may be compromised. If a re-scan is warranted, due to lack of adherence to following the prep instructions, there will be a charge for a new scan.

By signing this form below I hereby acknowledge that (1) I have read and understood all the above paragraphs; (2) I was given the opportunity to ask questions; (3) any questions I asked were answered to my satisfaction; (4) I have received sufficient information to make an informed decision to undergo thermal imaging; (5) I understand no guarantee or promises are being made that any risk for current and/or future injury or disease can or will be detected at the time of imaging; and (6) I hereby authorize and consent to thermal imaging on this date.

Print Name: _____ **Date:**_____

Signature: _____