

# Abdomen/Face/Back Health History

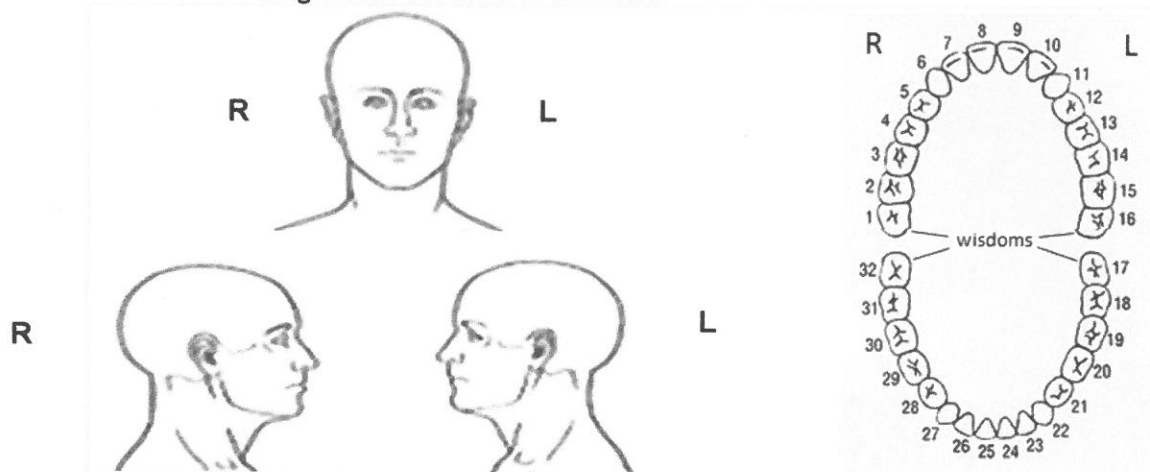
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Scan: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: F  M  Initial Exam  Follow-up Exam

**Face and Anterior neck:**  None

- Facial Pain       Facial Numbing       Tooth/Tooth Socket Pain       TMJ Pain or Clicking
- Sinus Concerns       Allergies       Thyroid       Lymph Node
- Headaches
- Please Describe \_\_\_\_\_

Place an "x" on the diagram in the area of concern.



**History of:**  None

- Stroke       Cardiovascular Disease       Dizziness       Fainting

Please Describe: \_\_\_\_\_

**History of:** Root Canal  Yes  No      Wisdom Tooth Extraction  Yes  No

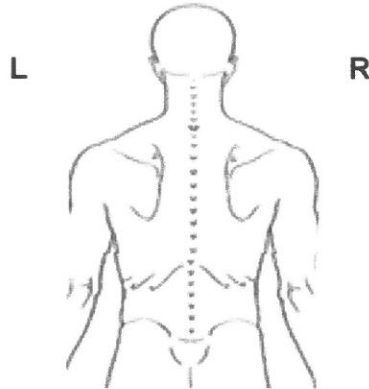
Please Describe: \_\_\_\_\_

**Posterior Neck and Back:**  None

Pain:     Neck             Upper Back             Mid Back             Lower Back

Please Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Place an "x" on the diagram in the area of concern.



**Respiratory Concerns:**

Asthma             Shortness of Breath             Lung Infection             Lung Pathology

Please Describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Kidney Concerns:**

Stones     Infection     Other

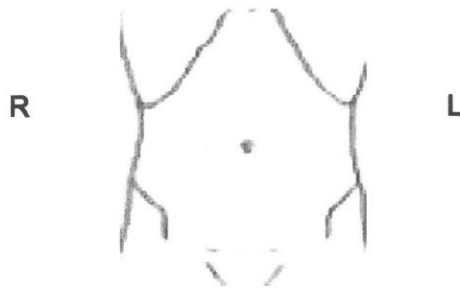
Please Describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Abdomen and Pelvis:**  None

Liver     Gall Bladder     Stomach     Digestion     Elimination  
 Uterus     Bladder             Right Ovary     Left Ovary

Please Describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Place an "x" on the diagram in the area of concern.



**Past Injuries to the abdomen back or face:**  None

Please Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Diagnosed diseases:**  None

Please Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past surgeries to the abdomen, face back (Please provide year of surgery):**  None

Please Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Please do not write in this section**

Tech: JULIE STEELE, CCT Patient T: \_\_\_\_\_ F Laboratory Temperature: \_\_\_\_\_ C

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**Additional Technician Notes**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## INFORMED CONSENT FOR TESTING PROCEDURE

Thermal imaging is a technology which measures the surface temperature of the body using infrared cameras and is analyzed to provide physiological information as an adjunct to standard screening and diagnostic testing. Initial \_\_\_\_\_

I understand that thermal imaging does not and cannot directly detect or be used to diagnose injury or disease of any kind and that the information is designed to be used with other examinations as an aid to the diagnostic process. Nor can it rule out the presence of injury or disease since some conditions do not produce sufficient temperature changes at the surface of the body to be seen with thermography. Therefore, injury or disease may still be present despite a lack of thermal findings present on examination. All concerns require evaluation by a doctor regardless of the thermal imaging results. Use of thermography as a stand-alone detection examination is not recommended as it can result in the failure of an existing condition to be detected. Initial \_\_\_\_\_

I further understand that not all organ systems, dental conditions, and medical conditions will produce thermal findings that will enable detection. Therefore I understand that this test cannot determine if an organ is diseased or healthy and it cannot diagnose disease. It is a functional test which may provide general regions to evaluate more thoroughly by a health care provider. It cannot replace or rule out the need for examination or additional testing. Initial \_\_\_\_\_

I confirm that I have followed the written pre-examination protocols for thermal imaging provided to me before the examination. I understand that if I did not receive and follow these protocols, the accuracy of my examination may be compromised. Initial \_\_\_\_\_

By signing below, I hereby acknowledge that (1) I have read and understood each of the above paragraphs; (2) I have had an opportunity to ask any questions I may have had; (3) any questions I asked were answered to my satisfaction; (4) I have received sufficient information with respect to thermal imaging to make an informed decision to undergo the procedure; (5) I understand no guarantee or warranty is being made that all risk for current and/or future injury or disease will be detected; and (6) I hereby authorize and consent to thermal imaging.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## STATEMENT OF INDEPENDENT OPERATIONS:

I understand and agree that Robert L. Kane, D.C., D.A.B.C.T., dba Kane Thermal Imaging Interpretive Services (collectively referred to as "Kane Interpretive Services") is a California based company that contracts with the provider of your imaging services solely for the purpose of interpreting and reporting thermal imaging scans. Your provider is not an employee, officer, director, partner, representative or agent of Kane Interpretive Services. Nor is Kane Interpretive Services an employee, officer, director, partner, representative or agent of your provider. Kane Interpretive Services is a wholly separate business entity from your provider and does not oversee or supervise your provider's thermography operations. Kane Interpretive Services is not involved in the design, manufacture, marketing, sale, rental, distribution, installation, inspection, repair or modification of any machinery or products used by your provider. Rather, Kane Interpretive Services is an independent contractor hired by your provider solely to interpret thermal imaging data and to report the results. Kane Thermal Interpretive Services does not control, nor have the right to control, your provider's business, including its equipment, operations, advertising and/or representations. Kane Interpretive Services makes no promises, warranties or representations, express or implied, as to your provider's services. In addition, Kane Interpretive Services owes no duty of care to me in connection with provider's services, including no duty to screen provider, no duty to protect or warn me of any actions or inactions of provider and no duty to investigate, communicate or mitigate any risks, known or unknown, relating to provider's services. I assume all duty of reasonable care to select, screen and monitor provider's services for my own safety and protection.

By signing this Statement of Independent Operations, I understand and agree with the foregoing and further agree that Dr. Robert L. Kane, D.C., D.A.B.C.T., dba Kane Thermal Imaging Interpretive Services is only responsible to me for the content of the thermal imaging report and its accompanying reporting guide.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Patient instructions for medical thermal imaging

BEFORE you arrive for your scheduled appointment, important PROTOCOLS MUST BE FOLLOWED in order to ensure that your images reflect accurate information. Please read the following instructions and adhere to them;

- No prolonged sun exposure or sunburns to the body areas being imaged **5 days prior to the exam.**
- No use of deodorants, lotions, oils, creams, powders, or makeup for full body or upper body scans **on the day of the exam.**
- No shaving or other hair removal of the areas to be imaged **on the day of the exam.**
- No treatment (chiropractic, acupuncture, TENS, physical therapy, electrical muscle stimulation, ultrasound, hot or cold pack use, sauna or steam room) or physical stimulation of the areas to be imaged **within 24 hours before the exam.**
- No exercise **on the day of the exam.**
- No showering 2 hours before the exam. No hot saunas or baths **within 24 hours before the exam.**
- No use of any drugs or pain medications **within 4 hours prior to your scan.** If necessary, consult with the prescribing physician for their consent prior to any change in use of medication(s).
- Wait at least 4 weeks after having a needle biopsy of the breast.
- Wait at least 8 weeks after having a lumpectomy or surgical biopsy of the breast before a thermogram scan can be performed.
- If you have had any medical procedures or a surgery within the last 3 months, please notify us before coming in for your appointment.

If you are scheduled for a breast thermogram, the same protocols above apply along with no physical stimulation of the breasts for 24 hours before the exam. If you are nursing, please try to nurse as far from 1 hour prior to your thermogram as possible.

**Please note:** During your appointment, you will disrobe and put on a gown in a private room (from the waist up for breast & upper body scans) No bras, belts, or elastic can be against the body 15 minutes prior to your scan. This is to allow for the surface temperature of the body to equilibrate with the room. A female technician is provided for all female patients.

If you have any questions, don't hesitate to call the office at (702) 825-3505.