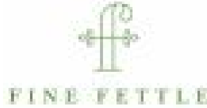

CLIENT INTAKE FORM

Name: ____DOB:__________Age:__________
Mailing Address:____
City/State/Zip:____ *Please indicate if it is ok to
Phone: Home (_____)________________ Cell (_____)______________ leave a voicemail: YES / NO
Email:______________________________________Occupation:___________________________
(For results and reminders ONLY; we DO NOT give out personal information)
Main concern today:

____

Symptoms/onset: Treatment:

____

____

Dental Work (root canals/crowns/fillings/extractions including wisdom/braces/mouth trauma; where and how many):

____

____

____

Previous illnesses/conditions:

____ Date:______________

____ Date:______________

Previous surgeries and injuries:

____ Date:_______________

____ Date:_______________

____ Date:_______________

Other screening tests/results in last 5 yrs:

____ Date:_______________

____ Date:_______________

____ Date:_______________

Family History:

____

____

____

Scars/Tattoos:

____

Current Medications: ____ How long? ___________

____ How long? ___________

____ How long?___________

TO THE BEST OF MY KNOWLEDGE, ALL INFORMATION IS CORRECT (Please sign below):

Signed:____ Screening Date:_____________

Breast Thermography Confidential Questionnaire

Name:___________________________________ **Date of Birth:** _______________

Address:________________________________ **City/State** ___________________ **Zip** ________

Email:_________________________ **Phone:** _________________ **Doctor:**_____________________

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Please answer Y (yes) or N (no) to the following questions:

Do you have any close relatives who have had breast cancer?_______
Have you ever been diagnosed with breast cancer? _______
Have you ever been diagnosed with any other breast disease (fibrocystic)?_______
Have you had any biopsies or surgeries to your breasts? _______
Have you had any breast cosmetic surgery or implants? _______
Have you had a mammogram in the past 12 months? _______
Have you had a mammogram in the past 5 years? _______
Have you had abnormal results from any breast testing? _______
Have you ever taken a contraceptive pill for more than 1 year? _______
Have you suffered from cancer of the womb? _______
Have you had pharmaceutical hormone replacement therapy? _______
Do you have an annual physical examination by a doctor? _______
Do you perform a monthly breast self exam? _______

How many mammograms have you had in total? ____________
What was your age when you had your first mammogram? ____________
How many births have you had? ____________ Your age at birth of first child: ____________
Did your periods start before the age of 12? ____________ Or finish after the age of 50? ____________
Do you smoke? Yes: _________ Never: _________ Not in last 12 months: _________ Not in last 5 years: _________
Have you recently had any of these breast symptoms? (Left or right breast)
Pain ______________
Tenderness ______________
Lumps ______________
Change in breast size ______________
Areas of skin thickening or dimpling ______________
Secretions of the nipple ______________

Extended Breast Questionnaire:

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

NAME: ____

DATE: _______________________

Diagnosed with breast cancer: _____
Cancer type: Metastatic_____ Local_____ Lymph node involvement_____
When diagnosed: Month_______ Year_______
Where (left breast): UO____ UI____ LO____ LI____ Nipple____
Where (right breast): UO____ UI____ LO____ LI____ Nipple____
Treatment: Surgery____ Chemo____ Radiation____ Other____ None____
Diagnosed with other breast disease:
Disease type: Fibrocystic____ Cystic____ Mastitis____ Abscess____ Other ____
(please report other types of disease in the history)
Breast biopsies or surgery:
Where (left breast): UO____ UI____ LO____ LI____ Nipple____
Where (right breast): UO____ UI____ LO____ LI____ Nipple____

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the Report.
By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature: _________________________

Today's Date: ______________

Thermal Imaging Protocols and Preparations Checklist

- Avoid having physical therapy, massage, or chiropractic care 24 hours prior to your scans
- Try to avoid taking any anti-inflammatory drugs 24 hours before scans as it could mask your body's symptoms.
- Refrain from smoking, chewing tobacco, or any product that contains nicotine the day of your scan unless ordered by your doctor
- Refrain from using lotions,deodorants, powders, essential oils, liniments the day of the scans.
- Avoid shaving or other forms of hair removal the day of your scans.
- Avoid sunlight and tanning beds the day of the scans. PLease reschedule if you have a sunburn.
- Please refrain from using your seat heaters/coolers the day of scans.
- Please refrain from caffeinated beverages for at least four hours prior to scans.
- Do not participate in vigorous exercise four hours before scans.
- Avoid bathing or showering in hot water four hours before scans.
- Please refrain from eating, drinking, and chewing gum one hour before scan.
- Do not use any Smart devices (cell phone, watches etc.) or have it on your body in the hour preceding your screening.
- I certify that I have complied with the above protocols. I understand that my appointment may need to be rescheduled if there are any reasons that could interfere with the accuracy of the scans. Full appointment fee may apply.

Patient signature:________________________________ Date:_________
(at time of appointment)

Authorization to Use or Disclose Protected Health Information

Patient Name:____
Address:
____

Date of Birth: ________________________ Date of Request:_________________

As required by the Privacy Regulations, *Fine Fettle* may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**
____

For the specific purpose of (describe in detail)
Interpretation of said images
____

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

____ ______________
Signature or Patient or Patient's Authorized Representative *Date*

____ ______________
Authorized Signature of Facility *Date*

CONSENT TO USE MEDICAL IMAGES AND HISTORY

1. I, ... full name of .... City/State do hereby give perpetual permission to Meditherm and its affiliates to use my images, case history and any supporting documentation in case reviews, peer review and advertising **provided that**:
   a. My identity is not directly or indirectly disclosed (except in confidentiality to the peer review board).
   b. Sufficient case matter is quashed to protect my identity as necessary.
   c. Meditherm and myself jointly own copyright to material supplied by myself, and copyright can not be inferred onto other entities without my express written permission.
   d. The information supplied shall not be used to cause harm or defame to any other person or profession.

2. Should these stipulations be breached, this consent is to be considered immediately revoked and all materials relevant to my case returned or destroyed.

3. Signed .... Dated ...., 2000

How your images, documents and history may be used.

Meditherm as a member of the American College of Thermology Inc, is currently compiling a database of case studies for use in future statistical analysis, case studies for teaching purposes, correlation studies and an image base for publicity and public education with known, accurate case histories.

Your identity (including information that could be suspected of leading to your identity) remains completely confidential, with only the case reviewers of the ACCT having access to your name (to verify any facts regarding your case).

No other organisation will have access to your records or will approach you directly for further information or solicite you for any further studies. Any copies of test results etc. that are passed on to us as a part of your case study will be edited to remove your name, address and any other contact or identity details before being used further.

Should you be asked to be a part of an ongoing study by us, all further imaging that forms a part of that study will of course be without charge as a thank you for your cooperation.

We thank you for your help. Your contribution is very much appreciated and not taken for granted.

The team at Meditherm