PATIENT INTAKE FORM - THERMOGRAPHY

CIRM
CENTER FOR
INTEGRATIVE & REGENERATIVE MEDICINE

10190 Critzer Shop Road, Afton, Virginia 22920
(434) 361-1896
Fax (540) 456-6161
www.cirm1.org

SAVE | **PRINT** | **RESET**

PATIENT INFORMATION

Last Name	First Name	M.I.	Date of Birth	Gender

Address	Apt.#	City	State	Country	Zip Code

Home Phone	Work Phone	Mobile Phone	Email Address

HEALTH HISTORY QUESTIONNAIRE

☐ Full Body Thermography
☐ Breast Thermography (Initial)
☐ Breast Thermography (Followup)
☐ Region of Interest _____
☐ Upper half of body
☐ Lower half of body

Symptom(s):_____

Current Treatment:_____

HEALTH HISTORY

Have you ever had a Thermogram? ☐ Yes or ☐ No If yes, Date: _____ Where:_____

Surgery/Dates:_____

Females Only Section: Applicable only for whole body or breast thermography

Mammogram History: (*if applicable*) _____

_____

_____

Any Abnormal Findings? ☐ Yes or ☐ No If yes, Findings:_____

_____ Dates:_____

OB/GYN: Any history of abnormal findings? ☐ Yes or ☐ No If yes, Findings:_____

_____ Dates:_____

Do you want your report sent to your Health Care Provider? ☐ Yes or ☐ **N**

Providers name and address: _____

_____

This information is confidential. All information is correct to my knowledge.

_____ _____ _____

Signature Print Name Date

BREAST QUESTIONNAIRE – BREAST SCAN

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.

BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONNAIRE

	YES	NO
1. Do you have any close relative who has had breast cancer? If yes, who?_____	☐	☐
2. Have you ever been diagnosed with breast cancer?	☐	☐
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	☐	☐
4. Have you had any biopsies or surgeries to your breasts?	☐	☐
5. Have you had any breast cosmetic surgery or implants?	☐	☐
6. Have you had a mammogram in the past 12 months?	☐	☐
7. Have you had a mammogram in the past 5 years?	☐	☐
8. Have you had abnormal results from any breast testing?	☐	☐
9. Have you ever taken a contraceptive pill for more than 1 year?	☐	☐
10. Have you suffered with cancer of the womb?	☐	☐
11. Have you had pharmaceutical hormone replacement therapy?	☐	☐
12. Do you have an annual physical examination by a doctor?	☐	☐
13. Do you perform a monthly breast self exam?	☐	☐

14. How many mammograms have you had in total? _____
15. What was your age when you had your first mammogram? _____
16. How many births have you had? _____ Your age at birth of first child._____
17. Did your periods start before the age of 12? ☐ Or finish after the age of 50? ☐
18. Do you smoke (***Check one***)? Yes: ☐ Never: ☐ Not in last 12 months: ☐ Not in last 5 years: ☐

	RIGHT BREAST	LEFT BREAST
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the 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.

Signature _____ Print Name _____ Date _____

EXTENDED BREAST QUESTIONNAIRE

Patient Name	Date of Birth

Have you ever been diagnosed with breast cancer? ☐ Yes or ☐ No

If yes, *Cancer type*: ☐ Metastic ☐ Local ☐ Lymph node involvement

When diagnosed: Month _____ Year _____

	Upper Outer	Upper Inner	Lower Outer	Lower Inner
Where (*left breast)*	☐	☐	☐	☐
Where (*right breast)*	☐	☐	☐	☐

Treatment: ☐ Surgery ☐ Chemo ☐ Radiation ☐ Other ☐ None

If other: _____

Have you ever been diagnosed with other breast disease? If yes, what type? ☐ Yes or ☐ No

Disease type: ☐ Fibrocystic ☐ Cystic ☐ Mastitis ☐ Abscess ☐ Other _____

Breast biopsies or surgery:

	Upper Outer	Upper Inner	Lower Outer	Lower Inner
Where (*left breast)*	☐	☐	☐	☐
Where (*right breast)*	☐	☐	☐	☐

General notes or comments:

PATIENT REVIEW OF BODY SYSTEMS

Patient Name	Date of Birth	Date

Constitutional

- ☐ Fevers/Chills/Sweats
- ☐ Unexplained weight loss/gain
- ☐ Fatigue/weakness
- ☐ Excessive thirst or urination

Musculo-Skeletal

- ☐ Muscle/Joint Pain

Ears/Nose/Throat

- ☐ Difficulty hearing/ringing
- ☐ Hay Fever/Allergies

Cardiovascular

- ☐ Other (*please specify)*

Dental

- ☐ Extractions
- ☐ Crowns
- ☐ Root Canal
- ☐ Gum Disease
- ☐ Fillings
- ☐ Other

Respiratory

- ☐ Cough/Wheeze
- ☐ Difficulty Breathing

Gastrointestinal

- ☐ Heartburn/Reflux
- ☐ Nausea/Vomiting/Diarrhea
- ☐ Large bowl dysfunction
- ☐ Abdominal Pain

Genitourinary

- ☐ Kidney/Bladder
- ☐ Reproductive organs

Skin

- ☐ Rash or Mole

Neurological

- ☐ Numbness
- ☐ Headaches

Organ Dysfunction

- ☐ Liver/Gall Bladder
- ☐ Spleen/Pancreas

Blood/Lymphatic

- ☐ Unexplained Lumps
- ☐ Easy Bruising

General Medical History: Past and Current medical problems (*please include dates)*

- ☐ Heart Disease: *(specify)*
- ☐ Diabetes
- ☐ Asthma/Lung Disease
- ☐ Accidents
- ☐ Other (*please specify)*
- ☐ High Blood Pressure
- ☐ Thyroid Problem
- ☐ Chemical Exposure
- ☐ Injuries
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Cancer (*specify*)

Family History: Please indicate the current status of your immediate family members (*Mother, Father, Sibling, Grandparent, Aunt, Uncle)*

- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Genetic Disorders
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Asthma/COPD
- ☐ Diabetes
- ☐ Bleeding or Clotting
- ☐ Other

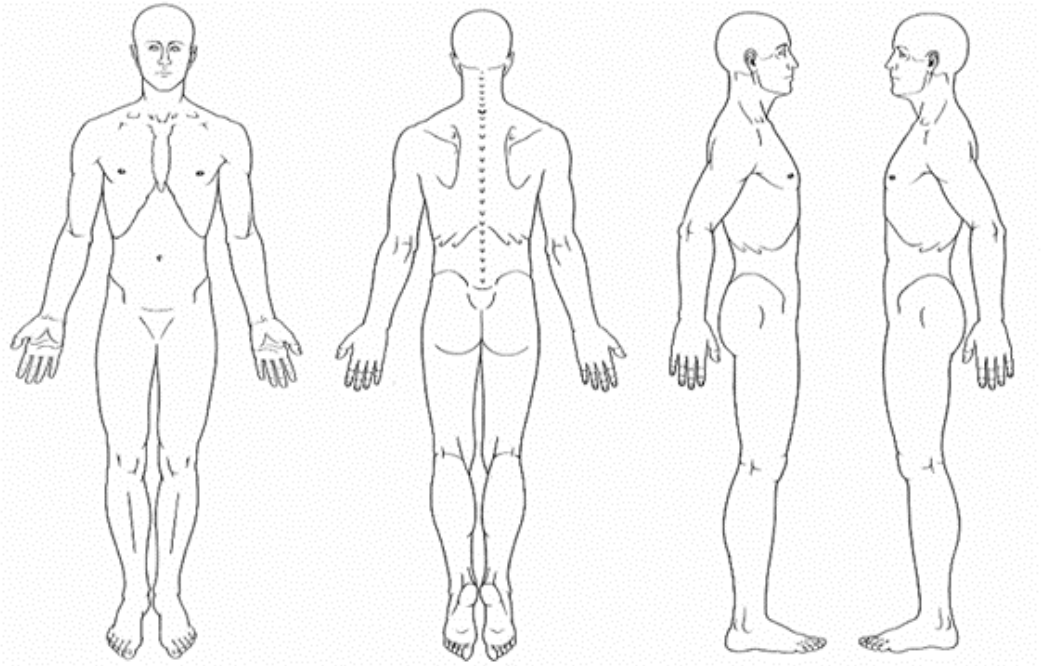
Type:_____

FULL BODY QUESTIONNAIRE/REGION OF INTEREST/SPECIAL INTEREST

Patient Name	Date of Birth	Date

Please use the symbols below to indicate area of:

Main Pain	X
Secondary Pain	0
Numbness	/////
Pins and Needles	:::::
Skin lesions / scarring (*mark location as they appear on your body*)	S



Please complete, if applicable:

Do you know what triggered the pain?

Does anything relieve it?

Does anything aggravate it?

Has it changed since it began?

Have you had any treatment?

Other comments:

Signature

Date

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name	Date of Birth

AS REQUIRED BY THE PRIVACY REGULATIONS, *C.I.R.M.* 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**

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.

Signature of Patient or Patient's Authorized Representative

Printed Name

Date

Authorized Signature of Facility

Date

INFORMED CONSENT FORM

PLEASE READ THE FOLLOWING AND SIGN BELOW.

I understand:

- C.I.R.M. and its staff of thermographers will use Digital Infrared Thermal Imaging (DITI) to take images of specified region(s) of my body as requested.
- These images may identify abnormal heat patterns indicating objectively the body's response to pain and dysfunction and may require further investigation.
- My images will be interpreted by the medical staff at Electronic Medical Interpretation (EMI) Inc. (thermology group). The Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment and NOT intended for self-evaluation or self-diagnosis.
- DITI is not a substitute for adequate medical care and I intend to remain under the care of my primary healthcare provider.
- The Report will not tell me whether I have any illness, disease or condition, but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the Report.
- DITI is not a replacement for any anatomical imaging (mammogram/ultrasound/MRI).
- I am responsible for my own decisions regarding my health, wellness and nutrition. Therefore, I hold C.I.R.M. harmless as to the results and interpretations resulting from this process.
- C.I.R.M. will keep all information shared by me completely confidential unless I provide a release in writing or as required by law (HIPAA).

ACKNOWLEDGEMENT

By signing below, I certify that I have read and understand the statements above and consent to the examination.

_____ _____

Client Signature Date