Radiant Health Imaging Patient Intake Form

For office use only:

Patient ID# ______________ Next Appt.____________

Report Ref # _____________ BR1 BR2 BRA HB FB ROI

Referred by ____________________________________

Location _____________ Scans uploaded____________

Data updated ___________ called _________________

RC___ Pt rpt sent_________ HCP rpt sent __________

Pymt _________ ck #________ V MC Disc Amx CD/Prt

Name ___________________________________

DOB ________________ Age ______________

Street ___________________________________

Town ___________________________________

State, Zip _______________________________

Occupation ______________________________

E-mail __________________________________

Phone (please include area code) (H) ______________________ (W) _______________________

(C) ________________________ Leave message w/results? Yes / No

Reason for today's visit: ____

Current Symptoms: ____

____

Current Treatment: ____

Current skin lesions/locations: ____

Health History:

Previous illnesses: ____

____

Previous Surgeries/Dates: ____

Injuries/Dates: ____

Current Medication(s): ____

Do you want your report sent to your Health Care Provider? (circle one) Yes No

Providers name and address: ____

____

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

Signature: ____ Date: _______________________

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Breast Thermography Confidential Questionnaire

Name:____ DOB: ________________

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

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? Yes__ No __ Never __ Not in last 12 months __ Not in last 5 years__

Have you recently had any of these breast symptoms:	Right Breast	Left Breast
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

Signature __________________________________ Date _________________________

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Authorization to Use or Disclose Protected Health Information

Radiant Health Imaging, Inc.

Patient Name:____

Address: ____

Date of Birth: ____________________ Date of Request:______________________

As required by the Privacy Regulations, *Radiant Health Imaging, Inc.* 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, Inc.

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

For the specific purpose of: **Interpretation of said images**

Effective date for this authorization: ______________________________

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

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*

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Patient Review of Body Systems

Name: ______________________________________DOB: _____________ 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

___Chest Pain/Discomfort

___Leg Pain w/Exercise

___Palpitations

Other (please specify)

____

____

Dental

___Extractions

___Crowns

___Root Canal

___Gum Disease

___Fillings

___Other

Respiratory

___Cough/Wheeze

___Difficulty Breathing

Gastrointestinal

___Heartburn/Reflux

___Nausea/Vomiting/Diarrhea

___Large bowel 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: (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

___High Blood Pressure

___Stroke

___Asthma/COPD

___Diabetes

___Bleeding or Clotting

___Other

___Cancer: type ____

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Full Body Questionnaire

Name: ____ DOB:_____________

Please use the symbols below to indicate areas of:

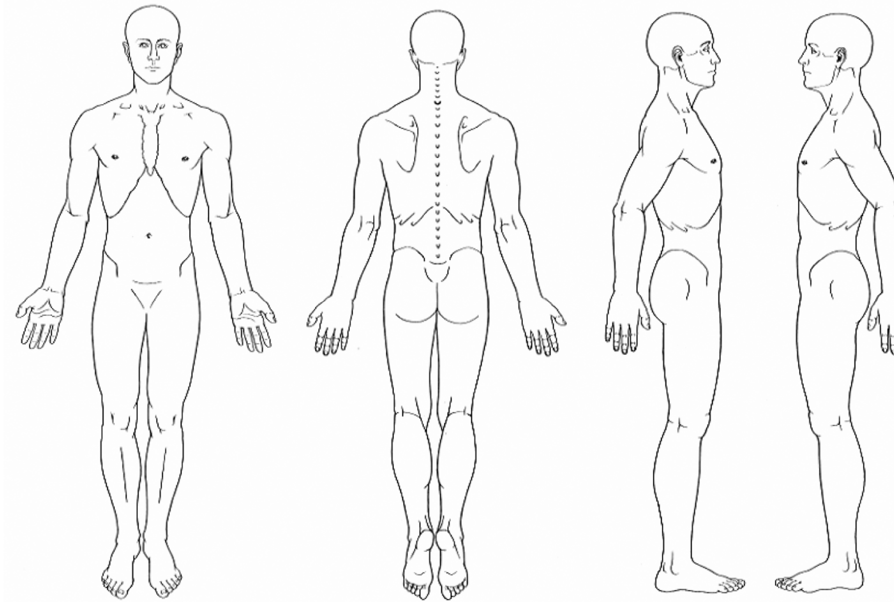
Main Pain *

Secondary Pain ·

Numbness ////////

Pins and needles ::::::::

Skin lesions / scarring (mark location as they appear on your body)



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_______________________________

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Patient Preparation Sheet/Full Body Scan

Purpose of test:

- Determine the cause of pain.
- Evaluate sensory-nerve irritation or significant soft-tissue injury.
- To define a previously diagnosed injury or condition.
- To identify an abnormal area for further diagnostic testing.
- For early detection of lesions.
- To monitor progress of healing and rehabilitation.
- To provide objective evidence.

Patient Preparation:

Prior to your appointment **do not** (on the day of):

- have physical therapy or electromyography
- use a tanning booth
- smoke for 2 hours before the test
- do not use lotions, powders, anti-perspirants, or makeup
- have strenuous exercise
- shave any part of your body
- perform skin brushing
- use therapeutic essential oils
- have kidney dialysis

Do not have acupuncture treatment or body work **3 days** prior to appointment. Wait **3 mos**. post surgery, radiation therapy, and chemo therapy. Wait **3 mos.** post lactation, before scheduling an appointment.

If your hair falls below your neck you should wear it clipped or pinned up.

Attire – Loose fitting clothes and no jewelry around the neck.

No changes necessary for diet or medication.

General Information:

Procedure - non-invasive, no-contact, no radiation and FDA Approved.

Disrobing - remove all clothing and jewelry. Put on a gown or sarong supplied. Inform your thermographer if you have/had any recent skin lesions on your body

Thermography is performed by a female certified clinical thermographer and is completely private. There are no risks or side effects to the procedure.

Average time for the appointment is 30 min. for one or two body regions, 1 hour for half or full body.

Please bring your healthcare providers complete name and address if you want a copy of report and scans mailed to him/her.

We gladly accept personal check, cash, Visa/ MC/Disc/Amex for payment.

You are welcome to bring a companion or partner to be present during the scan.

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