Radiant Health Imaging Patient Intake Form

Name _____

DOB _____ Age _____

Street _____

Town/State/Zip_____

Occupation _____

E-mail _____

Phone (best #) _____

May we leave a msg? Y N

For office use only. Last scan date:

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 AMEX

How would you like your report sent? Please choose one: ☐ email ☐ print

Reason for today's visit: _____

Symptoms: _____

_____

Current Treatment/Rx: _____

For females, date of last clinical breast exam _____ and mammo/us _____

HEALTH HISTORY

Illnesses DX/Dates:_____

_____

Surgeries/Dates: _____

Injuries/Dates: _____

Family History:_____

_____

We will send a copy of your report to your *referring* Health Care Provider only, if requested.

Name and address:_____

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

Signed: _____ Date of Service:_____

Breast Thermography Confidential Questionnaire

Name:_____ DOB: _____ Date:_____

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	☐	☐

.

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

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

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

Effective dates for this authorization: _____
This authorization will expire upon written request.

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*

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

___Cancer: type _____

___High Blood Pressure

___Stroke

___Asthma/COPD

___Diabetes

___Bleeding or Clotting

___Other

Full Body Questionnaire

Name: _____ DOB:_____

Please use the symbols below to indicate areas of:

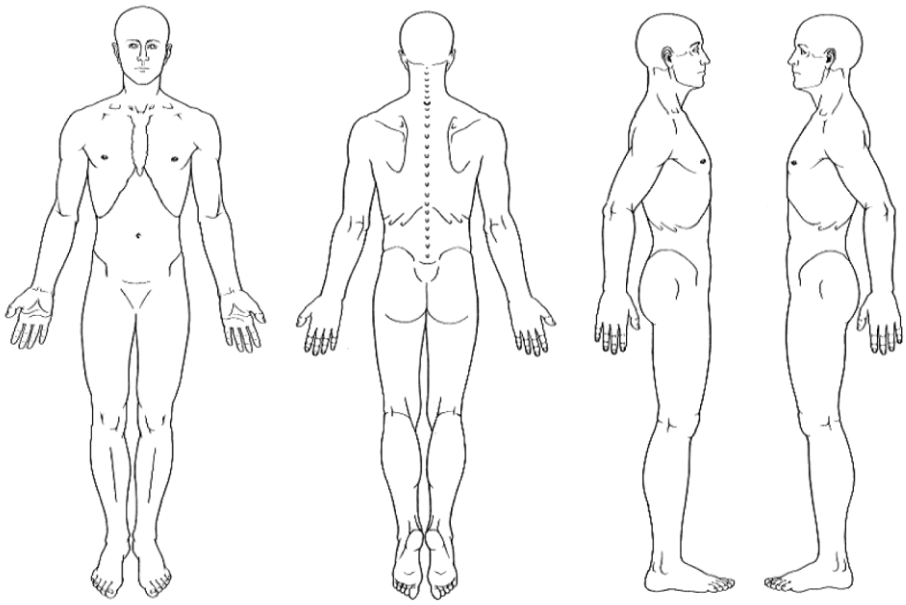
Main Pain *

Secondary Pain O

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:

_____

_____

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.

INFORMED CONSENT FORM

Please read the following and sign below.

I understand:

- Radiant Health Imaging, Inc. and it's staff of certified thermographers will use Digital Infrared Thermal Imaging (DITI) to take images of specified region(s) of my body as requested.
- The images may identify abnormal heat patterns indicating objectively the body's response to pain and dysfunction and may require further investigation.
- The images will be interpreted by the medical staff at Electronic Medical Interpretation (EMI) Inc. (thermology specialists). 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) rather an adjunctive tool.
- I am responsible for my own decisions regarding my health, wellness and nutrition. Therefore I hold Radiant Health Imaging harmless as to the results and interpretations resulting from this process.

Radiant Health Imaging, Inc 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.

_____

Name (please print) Date Date of Birth

_____

Client Signature

_____

Name, if other than client, and relationship to client