



Patient Intake Form

Name \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_

Street \_\_\_\_\_

Town \_\_\_\_\_

State, Zip \_\_\_\_\_

Occupation \_\_\_\_\_

E-mail \_\_\_\_\_

Phones (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

(Cell) \_\_\_\_\_ May we leave a message? Y N (Best No.)

Reason for today's visit: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Current Treatment: \_\_\_\_\_

Current Medication: \_\_\_\_\_

HEALTH HISTORY

Mammo History: \_\_\_\_\_

Illnesses/Dates: \_\_\_\_\_

Surgeries/Dates: \_\_\_\_\_

Injuries/Dates: \_\_\_\_\_

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.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

For office use only:	
Patient ID# _____	Next Appt. _____
Report Ref # _____	BR1 BR2 BRA HB FB ROI
Referred by _____	
Location _____	Scans uploaded _____
Data updated _____	called _____ Inv. Emailed _____
Pt rpt sent _____	HCP rpt sent _____
Pymnt _____	ck # _____ V MC DISC # _____
Send report Via: CD ___ Print ___ Encrypted Email ___	



Authorization to Use or Disclose Protected Health Information
Thermography Center of Montana

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date Request: \_\_\_\_\_

As required by the Privacy Regulations, Thermography Center of Montana, 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



## INFORMED CONSENT FORM

Please read the following and sign below.

I understand:

- Thermography Center of Montana and its staff of certified 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 Thermography Center of Montana harmless as to the results and interpretations resulting from this process.
- Thermography Center of Montana 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.

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Name (please print)

Date

Date of Birth

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Client Signature

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Name, if other than client, and relationship to client



## 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	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Change in breast size	<input type="checkbox"/>	<input type="checkbox"/>
Areas of skin thickening or dimpling	<input type="checkbox"/>	<input type="checkbox"/>
Secretions of the nipple	<input type="checkbox"/>	<input type="checkbox"/>

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Extended Breast Questionnaire

Patient 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 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)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart Disease: (specify) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol  |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Thyroid Problem     | <input type="checkbox"/> Kidney Disease    |
| <input type="checkbox"/> Asthma/Lung Disease      | <input type="checkbox"/> Chemical Exposure   | <input type="checkbox"/> Cancer: (specify) |
| <input type="checkbox"/> Accidents                | <input type="checkbox"/> Injuries            | _____                                      |
| <input type="checkbox"/> Other: (specify)         |  | _____                                      |

### **Family History: Please indicate the current status of your immediate family members**

**(Mother, Father, Sibling, Grandparent, Aunt, Uncle)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Bleeding or Clotting |
| <input type="checkbox"/> Genetic Disorders  | <input type="checkbox"/> Asthma/COPD         | <input type="checkbox"/> Other                |
| <input type="checkbox"/> Cancer: type _____ |  |   |

## Full Body Questionnaire/Region of Interest/Special Interest

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Please use the symbols below to indicate areas of:

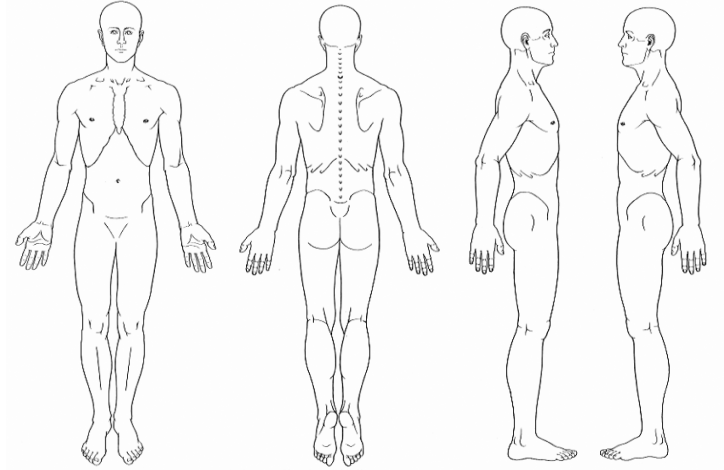
Main Pain \*

Secondary Pain ○

Numbness // // // // //

Pins and needles ::::: ::

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



Do you know what triggered the pain?

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Does anything relieve it?

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Does anything aggravate it?

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Has it changed since it began?

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Have you had any treatment?

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Other comments:

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Signature \_\_\_\_\_