THERMOGRAPHY OF HOUSTON

FOR OFFICE USE ONLY

Pt ID #: _____ Rpt #: _____

HB FB ROI - URGENT - INV

EM-C (PW: text / call) - M-C / M-D - LOC:_____

Patient Health History

Name _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Alt Phone _____

Occupation _____ Email _____

How did you hear about us? _____ Emergency Contact _____

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

Current Health Concerns _____

Troublesome Symptoms _____

What Aggravates Them _____

What Relieves Them _____

Name of Doctor and Type _____

Medications (including prescribed, hormones, and over the counter) _____

_____

Other Treatments Receiving _____

Anything else you think is important for us to know? _____

_____

Have you had a vaccine in the past 4 weeks? ❑ Yes* ❑ No

*If yes, date: _____ Which arm? ❑ Right ❑ Left

How would you like to receive your report? Email to Me Mail to Me Send to My Doctor*

**If sending to your doctor, please provide the following:*

Doctor's Name _____ Doctor's Phone # _____

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

Signed _____ Date _____

Printed Name _____

GENERAL HEALTH INFORMATION

Y N Do you feel that you are overweight? If so, how many pounds overweight? _____

Y N Have you lost any weight recently? If so, how many pounds? _____

Y N Do you smoke? ❑ Never ❑ Not in last 12 months ❑ Not in last 5 years

Y N Do you have any medical conditions or diagnoses? _____

_____

Please choose all of the conditions you have had in the past or currently have:

Abscesses	Diabetes	Herpes	Pelvic Inflammatory Disease	Sinusitis
Addiction	Emphysema	Influenza	Peritonitis	Sunstroke
Allergies	Epilepsy	Kidney Disease	Pleurisy	Stroke
Amnesia	Gallstones	Leukemia	Pneumonia	Syphilis
Arthritis	Goiter	Malaria	Prostatitis	Tuberculosis
Asthma	Gonorrhea	Measles	Rheumatic Fever	Typhoid Fever
Cancer	Gout	Miscarriage	Rubella	Venereal Warts
Chicken Pox	Hay Fever	Mononucleosis	Scarlet Fever	Warts
Cold Sores	Heart Disease	Mumps	Skin Disease	Whooping Cough
Depression	Hepatitis	Parasites	Strep Throat	Yellow Fever

Others _____

Y N Are there any of the above conditions after which you have never been totally well again, or which have been more severe than usual? Explain _____

Y N Have you had any operations? If so, what type and when? _____

_____

Y N Have you had any major injuries? If so, what type and when? _____

_____

Y N Do you exercise? If so, how often? _____

Y N Are you taking any of the following? If yes, list how much –

Alcohol _____ Tobacco _____

Caffeine *(coffee, tea, chocolate)* _____ Recreational drugs _____

Please choose all of the following conditions that have affected your relatives:

Alcoholism	Asthma	Diabetes	Paralysis	Stroke
Allergies	Cancer	Epilepsy	Pneumonia	Syphilis
Arthritis	Depression	Gonorrhea	Skin Disease	Tuberculosis

FAMILY HISTORY	**Age at Death**	**Ailments**
Mother		
Father		
Brothers		
Sisters		
Children		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

FULL BODY QUESTIONNAIRE

Please chose Y for Yes and N for No on the following questions:

HEAD & NECK

Y N Do you suffer with headaches? If yes, how often?_____

Y N Do you have allergies? If yes, to what? _____

Y N Do you have: ❑ TMJ OR ❑ Jaw clicks when chewing

Y N Do you currently have a cold?

Y N Are you being treated for a thyroid disorder? If yes, how? _____

Y N Do you have neck pain? If yes, describe _____

Y N Do you have a history of carotid artery disease?

Y N Do you have a family history of stroke?

Y N Do you currently suffer with sinus problems?

Y N Do you have any: ❑ dental crowns/caps ❑ root canals ❑ metal amalgams ❑ dental implants

If yes, list where these are in your mouth:_____

Y N Do you have: ❑ Gum disease ❑ Receding gums ❑ Bleeding gums

CHEST

Y N Have you ever been diagnosed with ❑ Heart Disease

If yes, please list diagnosis: _____

Y N Do you suffer with chest pain? If yes, describe _____

Y N Have you ever had surgery in the following area: ❑ Heart

Y N Do you have any special concerns or details related to the information given above? If so, please list:

_____

BACK

Y N Do you have pain in the following areas:

❑ Upper Back ❑ Lower Back

If yes, describe pain(s) _____

Y N Do you have: ❑ Asthma OR ❑ Shortness of breath

Y N Do you currently smoke?

Y N Have you smoked in the last 5 years?

Y N Have you ever been diagnosed with: ❑ Lung Disease ❑ Mid to Upper Spine Disorders

If yes, please list diagnosis: _____

Y N Have you had surgery or suffered with a condition (infection, etc.) in the following?:

❑ Lungs ❑ Mid to Upper Back ❑ Lower Back ❑ Kidneys

If yes, list surgery/condition and when _____

Y N Do you have any special concerns or details related to the information given above? If so, please list:

_____

FULL BODY QUESTIONNAIRE, Continued…

ABDOMEN

Y N Do you suffer from acid reflux? If yes, how often _____

Y N Do you have pain in the following areas:

❑ Stomach ❑ Abdomen (upper/lower) ❑ Below Right Breast

If yes, describe pain(s) _____

Y N Do you experience:

❑ Constipation ❑ Diarrhea ❑ Bloating ❑ Indigestion

Y N Have you had surgery or suffered with a condition (infection, etc.) in the following?:

❑ Stomach ❑ Spleen (upper left) ❑ Liver (upper right) ❑ Intestines ❑ Abdomen

If yes, list surgery/condition and when: _____

Y N Do you have any special concerns or details related to the information given above? If so, please list:

_____

ARMS & HANDS

Y N Do you have pain in the following? If yes, describe pain(s) _____

❑ Shoulder RT LT ❑ Elbow RT LT

❑ Arm RT LT ❑ Hands RT LT

Y N Have you had surgery or suffered with a condition (tear, broken bone, etc.) in the following?:

❑ Shoulder RT LT ❑ Elbow RT LT

❑ Arm RT LT ❑ Hands RT LT

If yes, list surgery/condition and when: _____

Y N Do you have any special concerns or details related to the information given above? If so, please list:

_____

LEGS & FEET

Y N Do you have pain in the following? If yes, describe pain(s) _____

❑ Leg RT LT ❑ Sciatica RT LT

❑ Buttocks/Hip RT LT ❑ Knees RT LT

❑ Ankles RT LT ❑ Feet RT LT

Y N Have you had surgery or suffered with a condition (tear, broken bone, etc.) in the following?:

❑ Leg RT LT ❑ Sciatica RT LT

❑ Buttocks/Hip RT LT ❑ Knees RT LT

❑ Ankles RT LT ❑ Feet RT LT

If yes, list surgery/condition and when: _____

Y N Do you have any special concerns or details related to the information given above? If so, please list:

_____

INFORMED CONSENT FORM

Please read the following and sign below.

I understand:

- Thermography of Houston, LLC 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 of Houston, LLC harmless as to the results of the interpretation resulting from this process.
- Thermography of Houston, LLC will keep all information shared by me completely confidential unless I provide a release in writing 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

OPTIONAL:

- ❑ I give Thermography of Houston, LLC permission to use my thermal images for case reviews and educational and marketing purposes, provided that my identity and personal information is kept private and I can withdraw this permission at any time in writing

_____

Client Signature Date

Authorization to Use or Disclose Protected Health Information

Thermography of Houston, LLC

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by Privacy Regulations, *Thermography of Houston, LLC* may not use or disclose your protected health information except as provided in our Notice of Privacy Practice 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 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: _____
This authorization will expire upon written request.

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 disclosures 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 of Patient or Patient's Authorized Representative *Date*

_____ _____
Authorized Signature of Facility *Date*