



**Thermography Intake**  
 MEND Thermography  
 515-207-4803

Thank you for your interest in pursuing thermography at MEND. Please take some time to thoughtfully complete this form to give our thermologists the most accurate picture of your health.

**Accessing Your Report**

**Sign up for a Spruce Account for HIPAA secure reports**

1. Scan the QR code
2. Follow the link to download Spruce
3. Enter your information
4. You will be automatically connected to our Clinic



*Once your report is ready, you will be notified via Spruce App*

### Patient Information

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_  
 Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
 Gender:  Male  Female Occupation \_\_\_\_\_  
 Preferred method of communication:  Any  E-mail  Text  Call—may we leave a message?  Yes  No  
 Marital Status:  Married  Separated  Divorced  Widowed  Single # of Children \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_  
 Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_  
 Who can we thank for referring you? \_\_\_\_\_

### Health Information

Clinical Concerns \_\_\_\_\_  
 Current Symptoms \_\_\_\_\_  
 \_\_\_\_\_  
 Current Treatments:  Chiropractic  Massage Therapy  Acupuncture  Physical Therapy  
 Others (please list): \_\_\_\_\_  
 Current Prescription Medications & Over the Counter Medications  None  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Health Histories

**Thermogram History**  
 Previous Thermograms?  No  Yes: Reason(s) \_\_\_\_\_ Year(s): \_\_\_\_\_  
 Any noted abnormalities on thermogram?  No  Yes

Did you seek further testing?  No  Yes

If yes, what was the result? \_\_\_\_\_

**Surgical History:**

Previous Surgeries & Year?  None

\_\_\_\_\_ Year: \_\_\_\_\_ Year: \_\_\_\_\_

\_\_\_\_\_ Year: \_\_\_\_\_ Year: \_\_\_\_\_

Any C-section births?  No  Yes If yes, what year(s): \_\_\_\_\_

**Dental History:**  None  Implants  Root Canal(s)  Amalgam Fillings (silver fillings)  Gum Disease

Dentures  Other \_\_\_\_\_

Location and date(s): \_\_\_\_\_

**General History** Any serious illnesses/hospitalizations/injuries? (& year) \_\_\_\_\_

Are you considered high risk for any diseases?  No  Yes: please explain \_\_\_\_\_

**Family Health History:** (list any cancers, autoimmune, heart disease, diabetes, kidney disease, hypertension etc.)

**Medical Diagnoses?** \_\_\_\_\_

Please list any current skin lesions, scars, or physical abnormalities: \_\_\_\_\_

Any :  Tattoo(s)—Please list location(s) \_\_\_\_\_

Piercing(s)—Please list location(s) \_\_\_\_\_

*(Female Patients Only)*

**OB/Gyn History:**  None  Cervical Cancer  Hysterectomy  Ovarian Cysts  Uterine Cysts

Endometriosis  Other: \_\_\_\_\_

Explanation and date(s): \_\_\_\_\_

**Mammogram/Ultrasound History**

Date/Year of last mammogram: \_\_\_\_\_

Any noted abnormalities?  No  Yes

If yes, please explain. \_\_\_\_\_

# Breast Thermography Confidential Questionnaire

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Doctor: \_\_\_\_\_

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.

Please mark Yes or No as it applies to you:

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Do you have any close relative who has had breast cancer?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been diagnosed with breast cancer?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been diagnosed with any other breast disease (fibrocystic)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any biopsies or surgeries to your breasts?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had any breast cosmetic surgery or implants?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had a mammogram in the past 12 months?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a mammogram in the past 5 years?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had abnormal results from any breast testing?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever taken a contraceptive pill for more than 1 year?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you suffered with cancer of the womb?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had pharmaceutical hormone replacement therapy?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have an annual physical examination by a doctor?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you perform a monthly breast self exam?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____   |                          |                          |
| 15. How many mammograms have you had in total? _____  |                          |                          |
| 16. What was your age when you had your first mammogram? _____  |                          |                          |
| 17. How many births have you had? _____ Your age at birth of first child: _____   |                          |                          |
| 18. Do you smoke? Yes <input type="checkbox"/> Never <input type="checkbox"/> Not in last 12 months <input type="checkbox"/> Not in last 5 years <input type="checkbox"/> |                          |                          |
| 19. Had a vaccination in last 4 weeks? Indicate which arm? Left <input type="checkbox"/> Right <input type="checkbox"/> No <input type="checkbox"/>                       |                          |                          |

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"/> |

Patient Disclosure:

I understand that the Report generated from my images is intended for use by trained healthcare 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 an illness, disease, or other condition, but will be an analysis of the images with respect only to the thermographic findings discussed in the Report.

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

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

## Extended Breast Questionnaire

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

**Have you been diagnosed with any form of breast disease?**  No  Yes

If yes, please mark disease type:

- Cancer  Fibrocystic  Mastitis  
 Abscess  Cystic  Other \_\_\_\_\_

**Have you ever had a breast biopsy or breast surgery?**  No  Yes

If yes, please mark location of ALL biopsies or surgeries:

**Left Breast:**  Upper Outer  Upper Inner  Lower Outer  Lower Inner  Nipple

**Right Breast:**  Upper Outer  Upper Inner  Lower Outer  Lower Inner  Nipple

**If you have been diagnosed with breast cancer, please complete the following:**

**Cancer Type** (ie DCIS, invasive ductal, etc): \_\_\_\_\_

**Involvement:**  Local Only  Lymph Node Involvement  Metastatic

**Date of Diagnosis:** \_\_\_\_\_

**Location(s):**

**Left Breast:**  Upper Outer  Upper Inner  Lower Outer  Lower Inner  Nipple

**Right Breast:**  Upper Outer  Upper Inner  Lower Outer  Lower Inner  Nipple

**Treatment(s):**

Surgery  Chemo  Radiation  Other  None

**Other Comments:**

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## Informed Consent for Thermography

Please read carefully and sign below if you are in agreement with this consent form. Please ask questions if there is anything that you do not understand on this consent form.

I understand:

- Thermography is simply a procedure utilizing thermal imaging cameras to visualize and obtain an image of the infrared radiation (heat) coming from the surface of the skin. The Thermographic procedure is performed as an aid to the evaluation of abnormal temperature patterns which may or may not indicate the presence of a disease process.
- A thermogram is not a stand-alone diagnostic tool. It is an adjunctive tool, which while reliable, should be used by the primary care physician along with other diagnostic tests and analyses to arrive at a provisional or more complete diagnosis. No surgical procedure should be based on thermography alone.
- Thermography is not a replacement for any anatomical imaging tests (mammography, ultrasound, CT, MRI, etc). Results of your thermogram may require further investigation by one or more of these tests.
- I will be disrobed relevant to the area of study to allow the surface of my body to cool to an ambient room temperature. I will then be examined with a digital infrared thermal imaging camera by a certified thermographer.
- My images will be interpreted by a board qualified or board certified thermologist from Electronic Medical Interpretation Inc. This report will only be an analysis of the thermographic findings and will not a guarantee that an illness, disease, or condition is present or absent.
- It is my responsibility to provide my health care provider with my report for further diagnosis and analysis in the overall evaluation of my health. Thermography is not a replacement for medical care and I intend to remain under the care of my primary healthcare provider.
- I have been given a patient preparation form to ensure the most accurate thermographic evaluation possible. I have informed the thermographer of any skin lesions, bruises, wounds, etc. that may cause changes in my thermographic images.
- I am responsible for my own decisions regarding my health, wellness, and nutrition. Therefore, MEND Thermography cannot be held responsible for any decisions I make. MEND Thermography is not responsible for any supplements/care products I use or purchase through their store or online dispensary. I understand that I should talk with my physician before using any supplements or making lifestyle changes.
- I am aware that this procedure is not covered by insurance and that the office fee is due and payable at the time of service unless special provisions have been made with the office in advance.
- MEND Thermography will keep my information confidential unless I provide a written release or as required by law (HIPAA).

By signing below, I certify that I have read and understand the statements above, I have received satisfactory answers to all questions I may have had, and I consent to the thermographic examination.

Patient Signature: \_\_\_\_\_

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

Printed Name of Patient: \_\_\_\_\_

\*\*\*This release form allows us to send your thermographic images and medical history to the doctors that interpret the scans and provide the reports.\*\*\*

## Authorization to Use or Disclose Protected Health Information

*Mend Thermography / Mend Integrative Wellness Center LLC*

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

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

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

**As required by the Privacy Regulations, Mend Thermography 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 (describe in detail)  
**Interpretation of said images**

**Effective dates** for this authorization: \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_  
This authorization will expire at the end of the above period.

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. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. 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*