Radiant Health Imaging   Patient Intake Form

For office use only.   Last scan date:

Patient ID# ______________ Next Appt.______________

Report Ref # __________ B1 B2 BA B+ WHC HB FB ROI

Referred by _____________________________________

Location _____________ Scans uploaded______________

Pymt __________ ck #_________   V MC DISC AMEX

Name ________________________________

DOB _________________   Age ___________

Street ________________________________

Town/State/Zip_________________________

Occupation ____________________________

E-mail ________________________________

Phone (best #) __________________________

May we leave a msg? Y N How would you like your report sent? ☐ 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:________________

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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

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: ______________________________
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*

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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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Half/Full Body Questionnaire

Name: ___________________________________ DOB:_____________ Date: ____________

Please use the symbols below to indicate areas of:

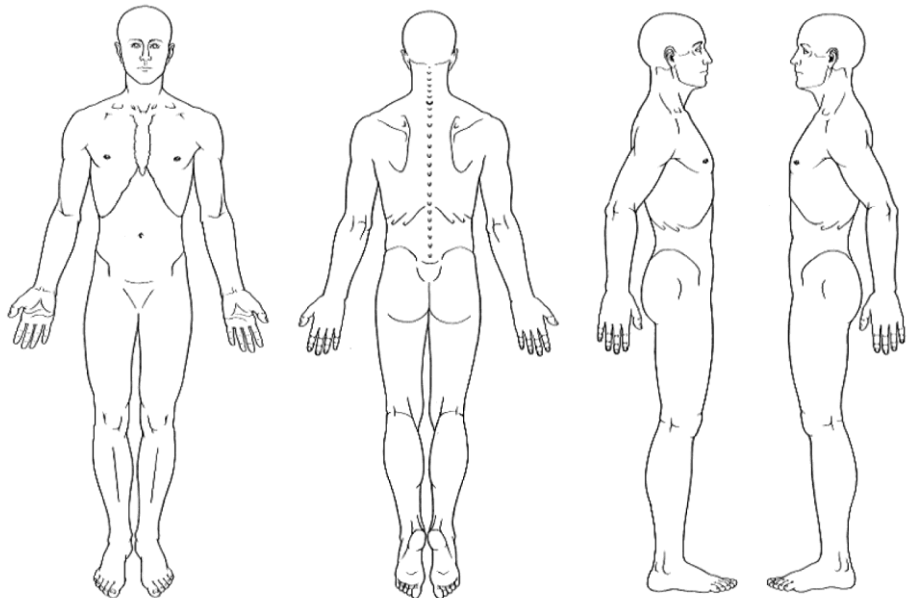
Main Pain *

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:

____

____

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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

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Patient Preparation Sheet/Half or Full Body

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 and avoid overexposure to the sun
- have strenuous exercise
- smoke for 2 hours
- shave your underarms or use lotions, powders, antiperspirants, therapeutic essential oils or makeup on the body
- do skin brushing
- have kidney dialysis

Do not have body work **2 days** prior. Do not have acupuncture treatment **3 days** prior. Wait **3 mos**. post surgery, radiation therapy, chemotherapy before scheduling appt. Wait **3 mos**. post lactation.

If your hair falls below your neck, please clip it up.

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

No changes necessary for diet or medication.

General Information

Procedure is non-invasive, no-contact, very private, no radiation.

Disrobing – remove all upper body clothing and jewelry. Put on a gown supplied. Inform your thermographer if you had any recent skin lesions on the breast region; the inflammation may cause a false positive result.

Thermography is performed by a female certified clinical thermographer and is completely private.
You will be behind a curtain/screen while tech uses laptop to frame, focus and capture images.
There are no risks and no side effects.
Average time for the appointment is 30 minutes.
Please bring your REFERRING healthcare provider's name and address if you want a copy of your report and scans mailed to him/her.
We gladly accept personal check, cash, Visa/MC/Disc/AMEX for payment. Also HSA and FLEX accts.
If you have any questions, pls call our office. 641-469-6081

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

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