Thermography for Health NY

120 East 56th Street 12th Floor, New York, NY 10022
Phone: 212-838-8884
Email: Hello@ThermographyForHealthNY.com
Website: ThermographyForHealthNY.com

NEW PATIENT INTAKE QUESTIONNAIRE

Name: _____ DOB: _____ Home Phone: _____

Address: _____ Cell Phone: _____

Emergency Contact Name: _____ Relationship to You: _____ Phone: _____

Email: _____ Referred By: _____

Date of Last Thermography: _____ How would you like to receive your report: ☐ In Person ☐ By Mail ☐ Email

Current Health Concerns / Issues / Accidents? _____

_____

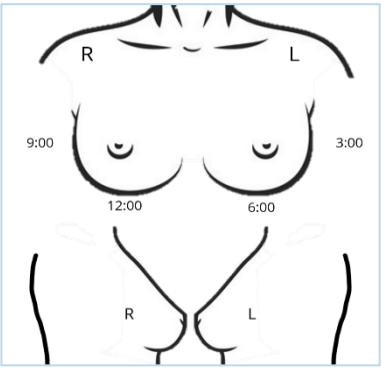
Current Medications: _____

Breast Questionnaire:

Have you ever been diagnosed with breast cancer? YES | NO
If YES, which type: Metastatic | Lymphatic Node
Removal | Local Date: _____/_____/_____
Diagnosed with other breast disease? YES | NO
If YES, describe: _____
Biopsies and findings? YES | NO
If YES, describe: _____
Breast surgery | Implants? YES | NO
Mammogram within 12 months? YES | NO
Total mammograms #_____
First mammogram: Age _____ or Date: _____/_____/_____
Contraceptive over 1 year? YES | NO
Hormone therapy? YES | NO
Last MD breast exam: _____/_____/_____
Monthly breast self-exam? YES | NO
Menstrual periods before age 12? YES | NO
Are you currently breast feeding? YES | NO
Total births #_____ Age at first birth: _____

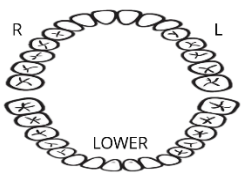
Breast symptoms in the last 6 months? Please indicate the location of your symptoms on the figures below using the following symbols:

T=Tenderness **L**=Lump **CS**=Change in Size **B**=Biopsy
D/T=Nipple Dimpling or Thickening **NS**=Nipple Secretion



Oral History:

RT=Root Canal **C**=Crown
MF=Mercury Fillings
S=Surgery **O**=Other

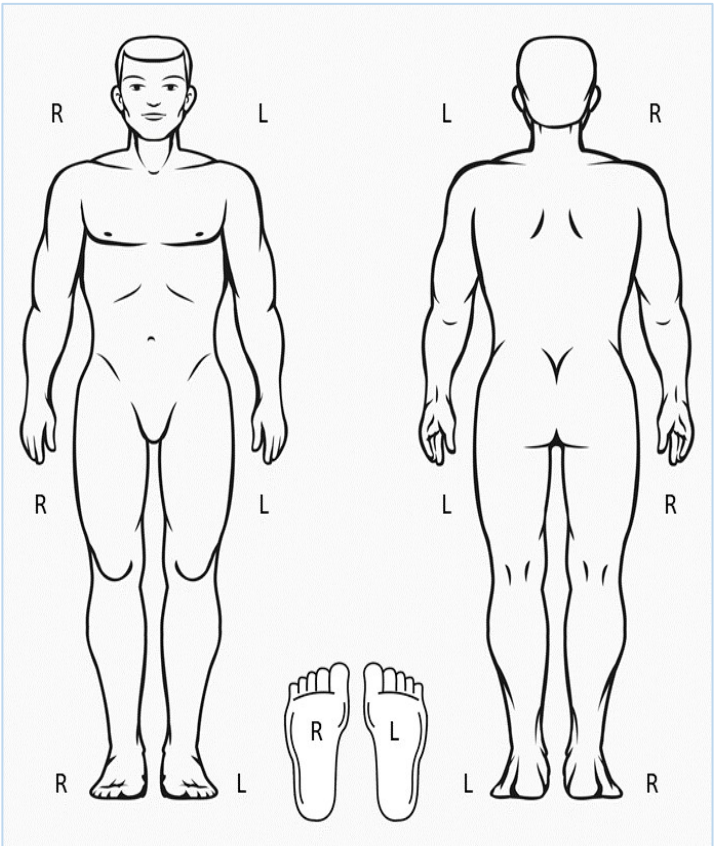


For Office Use Only: 1st Visit 3 Mos 1 Yr Recall Super Bill

Description: _____ Cost $ _____
Payment Method: Check # _____ Check / Cash $ _____
Credit Card Type: _____ # _____ Exp: _____
Billing Address: _____
Patient Signature: _____ Date: _____

Please indicate the location(s) of your symptoms on the figures below using the following symbols and scale: **SCALE: 1 – 10 for Pain** (10 is the worst pain)

X = Surgeries or Current Or Prior Diseases with brief description
N=Numbness **S**=Scars
F=Fractures **M**=Moles



Patient Disclosure: *I understand the report generated by my image is intended for use by trained health care providers to assist in evaluation, analysis, and treatment. I understand 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 of the areas discussed in the report. By signing below, I acknowledge and certify that I have read and understand the statements above and consent to the examination. I also authorize the release of information and the receipt of information in the pursuit of comprehensive evaluation and treatment relating to the services provided by Total Thermal Imaging and Thermography for Health NY.*

_____

Patient Signature (or Authorized Representative) *Date*

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NEW PATIENT AUTHORIZATION

Name: _____ DOB: _____ Home Phone: _____

Address: _____ Cell Phone: _____

Emergency Contact Name: _____ Phone: _____

Email: _____ Referred By: _____

- ☐ I understand the report generated by my images is intended for use by a trained health care provider to assist in evaluation, diagnosis, and treatment.
- ☐ I understand the report is not intended for use by individuals for self-evaluation, diagnosis, or treatment.
- ☐ I understand 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 of the areas discussed in the report.
- ☐ I authorize the release of information and the receipt of information in the pursuit of comprehensive evaluation and treatment relating to the services provided by Total Thermal Imaging or Thermography for Health NY or any other entities such as those related above.
- ☐ I understand that my report will be sent to me via electronic mail. If by chance an email address is not available, my report will then be sent to me via postal service.
- ☐ I acknowledge that there is a fee of five dollars should I need any additional copies of my report printed.

Authorization to use or disclose protected health information as required by HIPAA, the privacy regulations: Total Thermal Imaging or Thermography for Health NY may not use or disclose your protected health information without your notification, except as provided in our notice of patient privacy practices.

- ☐ I hereby authorize Total Thermal Imaging and any of its employees to use or disclose any patient health information to the following persons, entities, or business associates of this establishment: Total Thermal Imaging and Thermography for Health NY.
- ☐ I authorize the following patient information to be disclosed: thermal images and related health history.
- ☐ I authorize the above patient information to be disclosed for the specific purpose of generating a Report of Thermal Findings and impressions of the images generated.
- ☐ I understand that I have the right to revoke this authorization by sending a written notice to this office and that revoking will not affect previous reliance on the uses or the disclosure pursuant to this authorization or knowledge of any remuneration involved due to any marketing activity as allowed by this authorization.
- ☐ I understand that as a result of this authorization the patient has a right to inspect a copy of the patient health information being used or disclosed under federal law and to restrict what is disclosed with this authorization.
- ☐ I understand that refusal to sign this authorization still authorizes the patient to receive a copy of this authorization and to restrict what is disclosed with this authorization.
- ☐ I understand that if I do not sign this document, it will not condition my treatment, does not release me from payment, enrollment in health plan or eligibility for benefits, or negate restrictions on disclosure of protected patient health information.

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

_____ Date: _____

Signature of Patient or Patient's Authorized Representative

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SLEEP DISORDER ASSESSMENT

Name: _____ DOB: _____ Home Phone: _____

Email: _____ Cell Phone: _____

Today's Date: _____ Referred By: _____

PART 1

1.	Have you ever been told you have Congestive Heart Failure?	YES	NO
2.	Have you ever been told you have Coronary Artery Disease?	YES	NO
3.	Have you ever had a stroke?	YES	NO
4.	Do you take 3 or more medications for high blood pressure?	YES	NO
5.	Have you ever experienced irregular heart rhythms (atrial fibrillation)?	YES	NO
6.	Have you ever been told that you stop breathing at night?	YES	NO
7.	Do you have Diabetes?	YES	NO

PART 2

1.	Have you ever been told that you snore loudly?	YES	NO
2.	Do you often feel tired, fatigued, or sleepy during the day?	YES	NO
3.	Do you awaken from sleep with chest pain or shortness of breath?	YES	NO
4.	Does your family have a history of premature death in sleep?	YES	NO
5.	Is your neck size larger than 15.5 (female) or 17.0 (male)?	YES	NO
6.	Have you ever been diagnosed with Obstructive Sleep Apnea?	YES	NO
7.	Are you currently being treated for sleep apnea?	YES	NO
7a.	If yes, are you using your apparatus every night?	YES	NO

EPWORTH SLEEPINESS SCALE

How likely are you to doze off while doing the following activities?
Please use the following scale: ***0****=Never* ***1****=Slight* ***2****=Moderate* ***3****=High*

1.	Being a passenger in a motor vehicle for an hour or more	0	1	2	3
2.	Sitting and talking to someone	0	1	2	3
3.	Sitting and reading	0	1	2	3
4.	Watching TV	0	1	2	3
5.	Sitting inactive in a public place	0	1	2	3
6.	Lying down to rest in the afternoon	0	1	2	3
7.	Sitting quietly after lunch without alcohol	0	1	2	3
8.	In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL: _____