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 (Street / City / State / Zip): : _____ 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? _____

_____

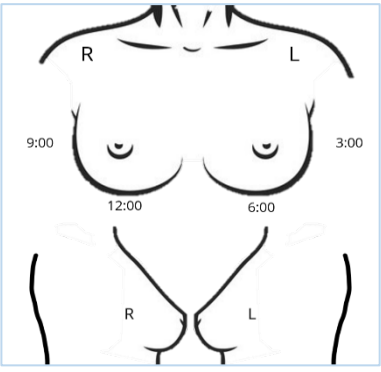
Current Medications: _____

**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: _____

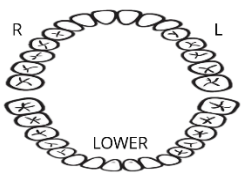
**Breast symptoms in the last 6 months? Please indicate the location of your symptoms on the figures below using the following symbols:**

**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

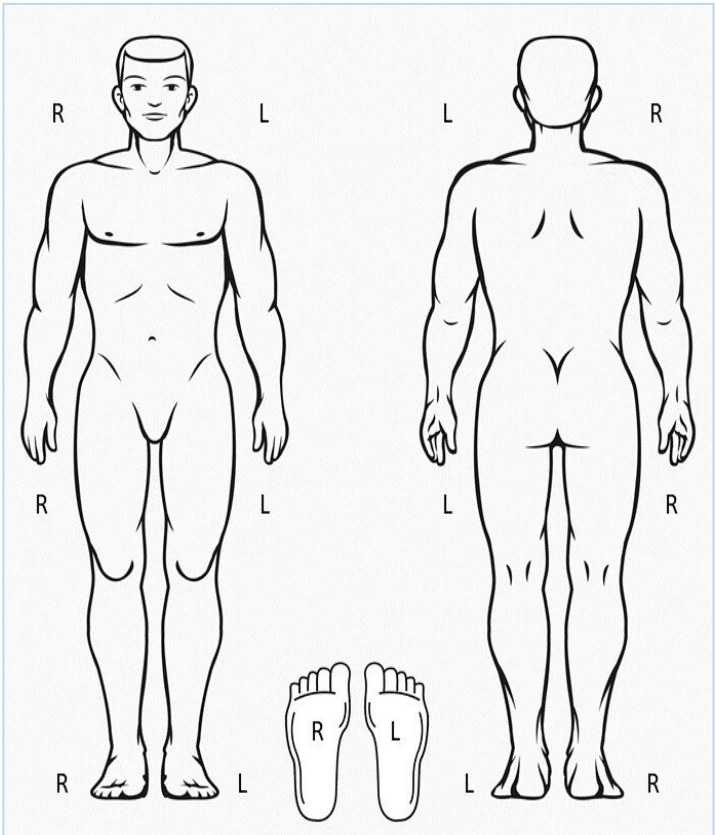



**For Office Use Only:** 1st Visit 3 Mos 1 Yr Recall Super Bill

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 Thermography for Health NY and Gregory Melvin DC / Masters of Healing. We are hereby exercising our right of freedom of association. This means our association activities are restricted to the private domain only and outside the government entities, agencies, offices, agents, contractors and other representatives as provided by law.*

_____

*Patient Signature (or Authorized Representative)* *Date*

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# NEW PATIENT AUTHORIZATION

Name: _____ DOB: _____ Home Phone: _____

Address (Street / City / State / Zip): : _____ Cell Phone: _____

Emergency Contact Name: _____ Contact's 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 Gregory Melvin DC / Masters of Healing 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: Gregory Melvin DC / Masters of Healing 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 Gregory Melvin DC / Masters of Healing and any of its employees to use or disclose any patient health information to the following persons, entities, or business associates of this establishment: Gregory Melvin DC / Masters of Healing 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.**

_____

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

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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: _____

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_____

*Patient Signature (or Authorized Representative)* *Date*