Victoria Bailey
Thermography, Health, & Wellness

INITIAL VISIT

256 Seaboard Lane, H-103 Franklin TN 37067 **615-934-3121**

Name: _____ D.O.B. _____

Address: _____

Phone: _____ E-mail: _____

Occupation: _____ How did you hear about us:_____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

Please note: It is our policy to not provide Thermography or Assisted Lymphatic Therapy services if you are pregnant, or are breastfeeding. We can provide Thermography 90-days post-partum and/or lactation, and Assisted Lymphatic Therapy once your infant has been weaned.

I understand that **Victoria Bailey Thermography, Health & Wellness** does not provide a medical diagnosis, but simply acts as the clinical Thermographer-transmitting digital pictures to EMI, a medical digital infrared thermal imaging service. An M.D. will interpret the images and return the images to **Victoria Bailey Thermography, Health & Wellness**. This evaluation may suggest further medical testing. If further testing is suggested I will consult my physician or health care provider.

I give my permission for the Clinical Thermographer at **Victoria Bailey Thermography, Health & Wellness** to take and submit DITI pictures for interpretation. I understand that by doing so, the Clinical Thermographer is not becoming my primary care physician. I understand that a set of thermography pictures and the medical report will be e-mailed to me so that I can share with my health care practitioner, primary care doctor, or anyone of my choosing.

I understand that the Report generated from my images is intended for use by trained health care 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 any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the Report. A doctor-to-doctor consultation can be arranged between Meditherm and your doctor if necessary.

I understand if I am receiving assisted lymphatic therapy, I hereby declare that I have provided all relevant information necessary for the proper application of this therapy and I agree to hold harmless, release and indemnify this therapist. I expressly give my permission for this therapist to provide such therapy.

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

Referring Physician's Name (*if applicable*): _____

Client Signature_____ Date_____

Thermographer's Signature_____ Date_____

All **Victoria Bailey Thermography, Health & Wellness** *clinical thermographers are trained and certified by the ACCT.*

IF YOU ARE A FEDERAL, STATE OR LOCAL AGENT, UPON ENTERING THESE PREMISES, YOU MUST DECLARE SAME UNDER THE BIVENS ACT - ARTICLE 42, AND BE HELD PERSONALLY AND INDIVIDUALLY LIABLE.

Significant Past Illnesses:

Illness	*Year(s)*	*Comments*

Previous Surgeries:

Type of Surgery	*Year(s)*	*Comments*

Present Health Problems *(please indicate current concerns and/or symptoms)*:

Medical Problem	*Date of Onset*	*Comments/Concerns/Symptoms*

Present Medications:

Medication Name	*Taken For*	*Date Started*

Family Medical History:

		Cancer History/Type	**Major Medical Health Problems** (*Mark in all that apply*)
Mother	○ Living ○ Deceased		○ Stroke ○ Heart Attack/MI ○ Diabetes ○ Hypertension ○ Other (specify): _____
Father	○ Living ○ Deceased		○ Stroke ○ Heart Attack/MI ○ Diabetes ○ Hypertension ○ Other (specify): _____

Do you participate in regular *(annual/bi-annual)* dental visits? ○ Yes ○ No

General overall health currently: ○ Excellent ○ Good ○ Fair ○Poor …….If *fair* or *poor*, please explain:

_____

Other Current Treatments:

_____

If you can answer "yes" to any of the 4 questions below, we cannot provide Lymphatic service		
Do you have any electrical medical devices?	Yes____ No____	
Have you had any organ transplants?	Yes____ No____	
Are you pregnant or lactating?	Yes____ No____	
Do you have a "diagnosed" deep vein thrombosis (DVT)?	Yes____ No____	

Additional questions		***If yes, explain in detail***
Do you suffer from headaches or migraines?	Yes____ No____	
Do you have chronic pain?	Yes____ No____	
Have you been diagnosed with any autoimmune dysfunction or disease?	Yes____ No____	
Do you use essential oils? Is the use of oils on your skin permissible?	Yes____ No____ Yes____ No____	

Type of Cancer	*Date of Dx*	**Where was/is cancer on the breast**
Metastatic	Mo Yr	L Breast UO UI LI LO Nipple
Local	Mo Yr	R Breast UO UI LI LO Nipple
Lymph node involvement	Mo Yr	**Treatment**: Surgery___ Chemo___ Radiation____ None____

Please answer all questions	*Yes*	*No*
1. Do you have any close relative who has had breast cancer? *Whom?* _____		
2. Have you ever been diagnosed with breast cancer? *(If yes, pls compete above)*		
3. Have you ever been diagnosed with any other breast disease (*fibrocystic, mastitis Cystic, abscess*)?		
4. Have you had any biopsies or surgeries to your breasts? Left or Right Date:_____		
5. Have you had any breast cosmetic surgery or implants? Left or Right Date:_____ If implants, under or over the muscle, saline or silicone filled (*pls circle answer*)		
6. Do you have dense breast tissue?		
7. Have you had a mammo in the past 12 months?		
8. Have you had more than 30 mammograms in your lifetime?		
9. Have you had a mammo in the past 5 years? If so, date of last mammo/ultrasound _____		
10. Have you had abnormal results from any breast testing?		
11. Have you ever taken a contraceptive pill for more than 4 years? If yes, how long _____		
12. Have you suffered with ovarian, uterine or cervical cancer?		
13. Have you ever had pharmaceutical/bio-identical hormone replacement therapy?		
14. Do you have an annual physical **breast** examination by a doctor?		
15. Do you perform a monthly breast self-exam?		
16. Did your menstrual cycle start before the age of 12?		
17. Did your menstrual cycle end after the age of 50?		
18. Are you still having a menstrual cycle?		
19. Have you ever given birth to a child? If yes, how many _____ **YOUR** age at first birth _____		
20. Have you ever smoked for more than 5 years?		
21. Is your menstrual cycle irregular?		
22. Do you experience cramping during your menstrual cycle?		
23. Do you experience heavy bleeding with your menstrual cycle?		
24. Do you have breast pain or tenderness that comes and goes?		
25. Do you have breast lumps that come and go?		
26. Do you have low libido *(low sex drive)*		
27. Do you experience hot flashes		
28. Have you ever been diagnosed with endometriosis?		
29. Have you ever been diagnosed with PCOS *(poly cystic ovarian syndrome)*		
30. Have you ever been treated for infertility?		
31. Do you have any swelling the neck or trouble swallowing?		
32. Do you have any thyroid disorders? *(hypo/hyperthyroidism, Hashimoto's/Grave's disease)*		
33. Do you regularly experience fatigue?		
34. Have you experienced recent hair loss?		

Have you RECENTLY had any of these breast symptoms?	*Right*	*Left*	*Subside after menstrual cycle?*
Pain			Yes____ No____
Tenderness			Yes____ No____
Lumps			Yes____ No____
Change in breast size			Yes____ No____
Areas of skin thickening or dimpling			Yes____ No____
Secretions of the nipple			Yes____ No____

Authorization to Use or Disclose Protected Health Information

As required by the Privacy Regulations, **Victoria Bailey Thermography, Health & Wellness,** 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 Client Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Client Health Information authorized to be disclosed: **Thermal Images and related health history.**
For the specific purpose of (*describe in detail*): **Interpretation of said images.**

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 in the use or disclosure pursuant to this authorization.
2. Have 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 Client's Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization, however by doing so, we will not be able to provide thermographic services.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility of benefits whether or not I provide authorization to use or disclose protected client health information.

_____ _____

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

_____ _____

Authorized Signature of Facility *Date*