WELCOME TO OUR THERMOGRAPHY LAB

We look forward to working with you and providing safe, effective thermal imaging. Please fill out the forms accurately and ask any questions if you need assistance. Call us at (205) 981-8090 as needed.

THERMOGRAPHY PROTOCOL

1. Please be approximately 15 minutes early for your appointment time.
2. Please bring in these forms, filled completely. If you cannot print them, please contact us ASAP so we can schedule you to come in earlier and fill them in person.
3. Please DO NOT bring small children to this appointment, because they will not be allowed in the room with you during your exam.
4. Payment for services is expected at the time of the examination, so please be prepared with credit, check, or cash.

IMPORTANT THINGS TO REMEMBER

1. If you have sunburn or fever, you will be rescheduled.
2. Avoid massage, physical therapy, analgesic (pain relief) creams, balms, magnets, poultice, and chiropractic adjusting for 24 hours prior to the examination.
3. No coffee, tea, soda, or other caffeinated/energy beverages for 4 hours prior to the exam.
4. No smoking or use of any nicotine products the day of your exam.
5. Do not stimulate the nipple in any way for 12 hours prior to the exam. Remove all necklaces and nipple rings.
6. Do not shave for 24 hours prior to the exam.
7. Do not use creams, lotions, deodorants, talcum powder, or other skin products the morning before the exam.
8. Do not perform any rigorous exercise program for at least 4 hours prior to your examination.
9. Do not bathe or shower in hot water for at least 4 hours prior to your exam.
10. Inform us if you have had radiation treatment within the last 6 months.
11. **DO NOT TOUCH OR RUB YOURSELF ANYWHERE NEAR THE BREASTS/AREA OF EXAM FOR 4 HOURS PRIOR TO THE EXAM.**

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Name _____ **Birthdate** _____

Address _____ **City** _____ **State** _____ **Zip**_____

Best telephone _____ **email** _____

Can we send email including reports with health info? _____**Who referred you to us?** _____

HISTORY. Please fill out entirely and explain yes answers in comments.

Fibrocystic Syndrome	___Yes ___No	Lumpectomy	___Yes ___No
Breast Cancer	___Yes ___No	Mastectomy	___Yes ___No
Breast Enlargement	___Yes ___No	Chemotherapy	___Yes ___No
Breast Reduction	___Yes ___No	Benign tumor	___Yes ___No
Silicone Implant	___Yes ___No	Radiation therapy	___Yes ___No
Biopsy	___Yes ___No	Breast trauma	___Yes ___No
Nipple Discharge	___Yes ___No	Lumps in breast/s	___Yes ___No
Last Mammogram	___Yes ___No	Results	
Do you use Progesterone Cream?	___Yes ___No	Birth control?	___Yes ___No
Family/personal history of breast cancer?	___Yes ___No		
Age of Menopause		Age of first menses	
Age you had first child?		How many pregnancies?	
# Live births?		Miscarriages?	___Yes ___No
Ages of biological children?		Time nursed	
Last menstrual date?		Current frequency?	
Difficult menstruation?	___Yes ___No	Do you consume caffeine?	___Yes ___No
Comments			

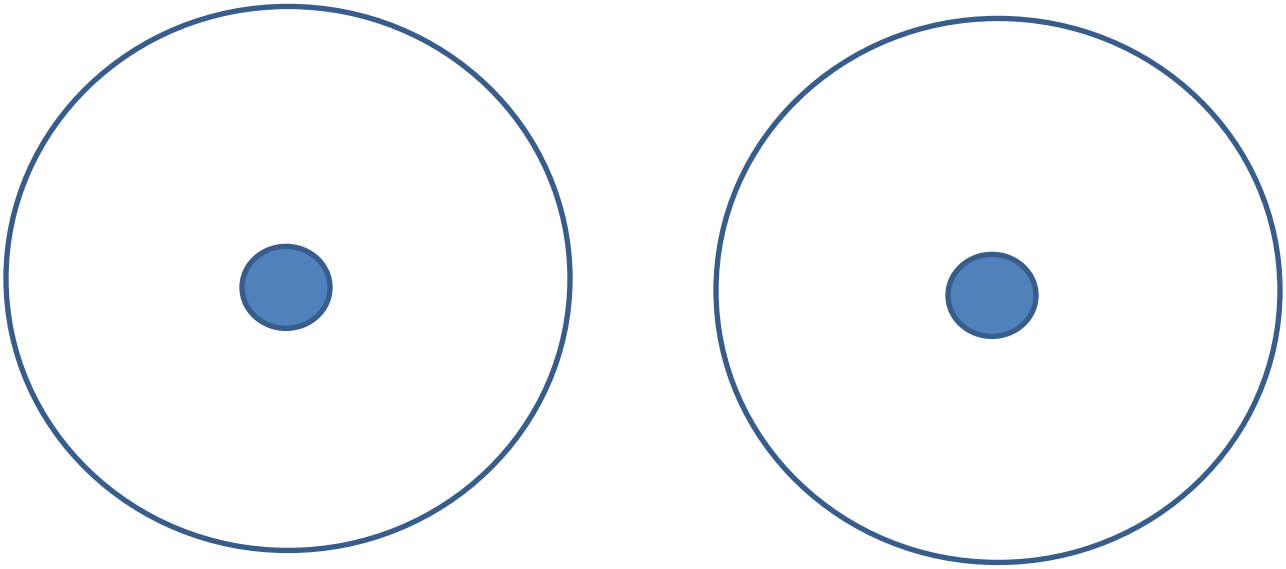
Surgeries? Please date and explain.

greystone CHIROPRACTIC

Name _____ **Date** _____

Breast Diagram. Please mark on this diagram using the following codes:

T= Tenderness L=Lump S=Scar I=Itching B=Burning P=Pain BS=Bioposy site



RIGHT **LEFT**

If none, check here ☐

Comments:

Specific concerns regarding breast/s:

Have you had breast thermography before? _____ **yes** _____ **no**

If yes, when & where? _____

What was the result? _____

_____

HIPAA Compliance- Your Protected health Information

Birmingham Wellness LLC, dba Greystone Chiropractic, strives to maintain a professional environment where your health information is protected and private as required by law. Concerning your private health information:

You have access to all of your health records and information as detailed below. You have rights with regard to how we contact you regarding your activity in the practice, i.e. appointment reminders, billing, or other matters related to your care. Our office and all of its employees take every effort and precaution to protect your private health information, and will not share it with any person or persons that you do not expressly allow in writing.

1. Greystone Chiropractic may contact the individual to provide appointment reminders or information about your case or treatment options, alternatives, or recommendations that may be of benefit to the individual.
2. Your information will not be shared with any 3rd party without your express written consent. Your images will be interpreted by an outside radiologist and their consultants, and you hereby grant permission for this purpose. Files will be transferred by email or other online upload techniques, which may or may not be encrypted.
3. Your records are available for your review with proper written notice. Any corrections that must be made will be done within 7 days of written notice.
4. We require written authorization to release your health information to a third party (such as another doctor's office), forms of which we can supply. Under no circumstances will we discuss your personal health information with a third party without your written consent.
5. I understand I can change my mind at any time to allow or disallow information sharing within 7 days of written notice.

I have received a copy of this Privacy Notice.

Signature Date

Print name