

# Patient Intake Form

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: (H) \_\_\_\_\_

(C) \_\_\_\_\_

(W) \_\_\_\_\_

## For Office Use Only

Patient ID# \_\_\_\_\_ Report Ref# \_\_\_\_\_

Scan Type: \_\_\_\_\_ Scan Location: \_\_\_\_\_

Referred by: \_\_\_\_\_

Date of R&S submitted to EMI: \_\_\_\_\_

Date of R&S processed & sent to Patient: \_\_\_\_\_

Date Patient called regarding R&S findings: \_\_\_\_\_

Patient Receipt Sent: \_\_\_\_\_ Patient Report/Images Sent: \_\_\_\_\_

Doctor/Health Care Provider Patient Report/Images Sent: \_\_\_\_\_

Payment: \_\_\_\_\_ Cash \_\_\_\_\_ Check#: \_\_\_\_\_ CC: V MC D AE

Processing: Email, CD or Printed Followed Protocol: Yes No

Next Appt: \_\_\_\_\_ Notes: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Current Symptoms (SX): \_\_\_\_\_

Current Treatment (TX): \_\_\_\_\_

Previous Illnesses: \_\_\_\_\_

Previous Surgeries/Dates: \_\_\_\_\_

Previous Injuries/Dates: \_\_\_\_\_

Current Medication(s): \_\_\_\_\_

Thermography (HX): \_\_\_\_\_

Doctor or Health Care Provider's Email: \_\_\_\_\_

Contact person in case of emergency:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

This document is confidential and legally privileged. Any retention, dissemination, distribution or copying of this communication is strictly prohibited. All information is correct to my knowledge

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Breast Questionnaire

- |   |     |    |
|---|-----|----|
| 1. Do you have any close relative who has had breast cancer?                                | Yes | No |
| 2. Have you ever been diagnosed with breast cancer?   | Yes | No |
| 3. Have you ever been diagnosed with any other breast disease (fibrocystic)?                | Yes | No |
| 4. Have you had any biopsies or surgeries to your breasts?                                  | Yes | No |
| 5. Have you had any breast cosmetic surgery or implants?                                    | Yes | No |
| 6. Have you had a mammogram in the past 12 months?  | Yes | No |
| 7. Have you had a mammogram in the past 5 years?  | Yes | No |
| 8. Have you had abnormal results from any breast testing?                                   | Yes | No |
| 9. Have you ever taken a contraceptive pill for more than 1 year?                           | Yes | No |
| 10. Have you suffered with cancer of the womb?  | Yes | No |
| 11. Have you had pharmaceutical hormone replacement therapy?                                | Yes | No |
| 12. Do you have an annual physical examination by the doctor?                               | Yes | No |
| 13. Do you perform a monthly breast self exam?  | Yes | No |
| 14. How many mammograms have you had in total? _____  |     |    |
| 15. What was your age when you had your first mammogram? _____                              |     |    |
| 16. How many births have you had? _____ Your age at birth of first child: _____             |     |    |
| 17. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____ |     |    |
| 18. Do you smoke? Yes__ No __ Never __ Not in last 12 months __ Not in last 5 years__       |     |    |

## **Have you recently had any of these breast symptoms:    Right Breast                      Left Breast**

Pain

Tenderness

Lumps

Change in breast size

Areas of skin thickening or dimpling

Secretions of the nipple

Notes: \_\_\_\_\_  
\_\_\_\_\_

## **Patient Disclosure**

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Extended Breast Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosed with breast cancer:

**Cancer type:** Metastatic \_\_\_\_\_ Local \_\_\_\_\_ Lymph node involvement \_\_\_\_\_

**When diagnosed:** Month \_\_\_\_\_ Year \_\_\_\_\_

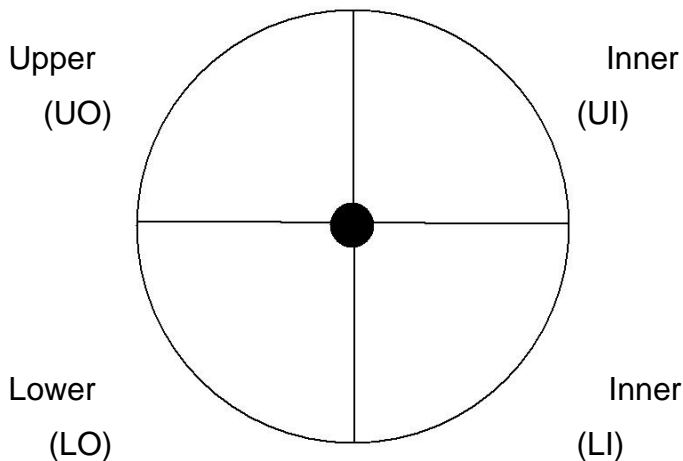
**Where:** Left Breast \_\_\_\_\_ Right Breast \_\_\_\_\_

**Treatment:** Surgery \_\_\_\_\_ Chemo \_\_\_\_\_ Radiation \_\_\_\_\_ Other \_\_\_\_\_ None \_\_\_\_\_

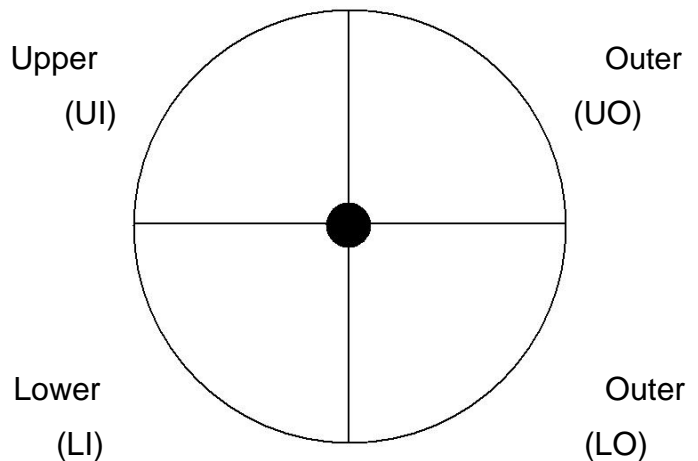
Other, please explain: \_\_\_\_\_

**Breast biopsies or surgery:** Please choose the area closest to the biopsy or surgery location based on the charts below. The exact location will be discussed and marked at your appointment. Extra scans will also be taken with a pointer to show the exact location for the doctor to review.

Left Breast



Right Breast



**Where (left breast):** UO \_\_\_\_\_

UI \_\_\_\_\_

LO \_\_\_\_\_

LI \_\_\_\_\_

Nipple \_\_\_\_\_

**Where (right breast):** UO \_\_\_\_\_

UI \_\_\_\_\_

LO \_\_\_\_\_

LI \_\_\_\_\_

Nipple \_\_\_\_\_

Diagnosed with other breast disease:

**Disease type:** Fibrocystic \_\_\_\_\_ Cystic \_\_\_\_\_ Mastitis \_\_\_\_\_ Abscess \_\_\_\_\_

Other, please explain: \_\_\_\_\_

*(Please report other types of disease in the health history, thank you)*

# Patient Review of Body Systems

## **Constitutional**

- Fevers/Chills/Sweats
- Unexplained weight loss/gain
- Fatigue/weakness
- Excessive thirst or urination

## **Musculo-Skeletal**

- Muscle or Joint Pain
- Leg Pain with Exercise

## **Ears/Nose/Throat**

- Difficulty hearing/ringing
- Hay Fever/Allergies

## **Cardiovascular**

- Chest Pain/Discomfort
- Palpitations

## **Dental**

- Extractions
- Crowns
- Root Canal
- Gum Disease
- Fillings
- Other \_\_\_\_\_

## **Respiratory**

- Cough/Wheeze
- Difficulty Breathing

## **Gastrointestinal**

- Heartburn/Reflux
- Nausea/Vomiting/Diarrhea
- Large bowel dysfunction

## **Skin**

- \_\_\_\_\_ Rash or Mole

## **Neurological**

- Numbness
- Headaches

## **Organ Dysfunction**

- \_\_\_\_\_
- \_\_\_\_\_

## **Blood/Lymphatic**

- Unexplained Lumps
- Easy Bruising

## **Other**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## **OB/GYN**

- Pap Smear Results:  Normal  Abnormal (please explain) \_\_\_\_\_
- Hysterectomy - Date: \_\_\_\_\_ Bladder Infections:  Yes  No
- Birth Control:  Yes  No If Yes: \_\_\_\_\_ Type \_\_\_\_\_ Amount \_\_\_\_\_

## **General Medical History: Past and Current medical problems (please include dates)**

- Heart Disease: (specify) \_\_\_\_\_
- High Blood Pressure  High Cholesterol  Diabetes
- Thyroid Problems  Kidney Disease  Asthma/Lung Disease
- Chemical Exposure  Cancer: (specify) \_\_\_\_\_
- Other: (specify) \_\_\_\_\_

## **Family History: Please indicate the current status of your immediate family members**

### **(Mother, Father, Sibling, Grandparent, Aunt, Uncle)**

- High Cholesterol  High Blood Pressure Other: \_\_\_\_\_
- Heart Disease  Stroke \_\_\_\_\_
- Bleeding or Clotting  Genetic Disorders \_\_\_\_\_
- Asthma/COPD  Diabetes \_\_\_\_\_
- Cancer: (type) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **MIDNIGHT SUN HEALING NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Midnight Sun Healing** is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### **Disclosure of Your Health Care Information**

#### **Treatment**

We may disclose your health care information to other healthcare professionals within our practice or associated with our practice for the purpose of treatment, payment or healthcare operations.

*“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers within or associated with **Midnight Sun Healing** for the benefit of providing you with more health care information.*

#### **Payment**

We email a receipt to you that can be sent to your insurance provider for the purpose of payment or health care operations.

*“As a courtesy to our patients, we email an itemized receipt for you to submit to your insurance carrier for the purpose of showing payment to **Midnight Sun Healing** for health care services rendered. The receipt contains our business information, your name and address, type of scan, price of scan, form of payment and date of service. If more information is needed please call our office at 920.660.3320 and we will be happy to assist you.*

#### **Workers’ Compensation**

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

#### **Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

#### **Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

#### **Judicial and Administrative Proceedings.**

We may disclose your health information in the course of any administrative or judicial proceeding.

**Law Enforcement.**

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

**Deceased Persons.**

We may disclose your health information to coroners or medical examiners.

**Organ Donation.**

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

**Research.**

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

**Public Safety.**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

**Specialized Government Agencies.**

We may disclose your health information for military, national security, prisoner and government benefits purposes.

**Change of Ownership.**

In the event that **Midnight Sun Healing** is sold or merged with another organization, your health information/record will become the property of the new owner.

**Your Health Information Rights**

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that **Midnight Sun Healing** is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that **Midnight Sun Healing** amend your protected health information. Please be advised, however, that **Midnight Sun Healing** is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by **Midnight Sun Healing**.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practices**

**Midnight Sun Healing** reserves the right to amend this Notice of Privacy Practices at anytime in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, **Midnight Sun Healing** is required by law to comply with this Notice.

**Midnight Sun Healing** is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: **Jacque Kress** by calling this office at 920.660.3320. If **Jacque Kress** is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**Complaints**

Complaints about your Privacy Rights or how **Midnight Sun Healing** has handled your health information should be directed to **Jacque Kress** by calling this office at 920.660.3320. If **Jacque Kress** is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

This notice is effective as of 01/01/2014.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide **Midnight Sun Healing** with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

- I consent to give **Midnight Sun Healing** permission to email my report and images to me and or my doctor or health care provider.

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Parent/Guardian (If under 18 years of age)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date