



## Thermal Imaging Instructions

Name \_\_\_\_\_ DOB \_\_\_\_\_

Body Temperature \_\_\_\_\_ Room Temperature \_\_\_\_\_ Technician \_\_\_\_\_

Welcome to Midwest Thermography. Before you arrive for your thermographic examination, certain protocols must be followed to ensure that your images reflect accurate information. Please initial each line confirming the following instructions have been followed:

### Initials

\_\_\_\_\_ Avoid sunbathing, artificial tanning, waxing and laser treatments to the areas being imaged. These must be done 5 days prior to the exam. If there are any burns or wounds on the areas being imaged, imaging may need to be postponed.

\_\_\_\_\_ Allow a minimum of 4-6 weeks after biopsy and 3 months after radiation before imaging. Elevated temperatures can still be detected from tissue healing up to a year after a lumpectomy or mastectomy.

\_\_\_\_\_ No IV and/or ozone therapy 36 hours prior to imaging.

\_\_\_\_\_ Do not use deodorants (including natural deodorants), antiperspirants, lotions, oils, creams (including hormone creams), powders, perfume, body sprays, makeup or anything topical on the areas being imaged.

\_\_\_\_\_ Avoid shaving the areas to be imaged for at least 24 hours prior to the exam. This includes underarms for breast thermograms, underarms and face for upper body thermograms, and legs for lower body thermograms.

\_\_\_\_\_ Avoid physical stimulation of the body such as massage, sexual activity, massage, TENS, physical therapy, electrical muscle stimulation (EMS), sauna, hot tub, steam room, ultrasound, hot or cold pack use for 24 hours prior to the exam.

\_\_\_\_\_ No exercise the day of the exam.

\_\_\_\_\_ No smoking for 2 hours prior to the exam.

\_\_\_\_\_ No showering for 1 hour prior to the exam. No baths 24 hours prior to the exam.

\_\_\_\_\_ If you are nursing, avoid nursing at least 1 hour prior to the exam. Please note the last time nursed and check which breast and/or both, if applicable. Time: \_\_\_\_\_ Left Breast \_\_\_\_\_ Right Breast \_\_\_\_\_

\_\_\_\_\_ For head and neck imaging, do not floss, brush your teeth, chew gum or drink hot liquids 1 hour prior to the exam.

\_\_\_\_\_ If not contraindicated by your doctor, avoid taking pain medications or vasoactive drugs the day of the exam.

During the examination you will be disrobed (from the waist up for breast exams, underwear may be worn for women and shorts for men for lower body exams.) Shoes and socks must also be removed. If you are cold sensitive bring or wear warm coverings for the areas not being imaged. The imaging room temperature is around 68 degrees F (21 degrees C.) You will acclimate in the room for 15 minutes prior to the test. A female technician is provided for all our female patients.

Please bring a list of medications you are currently taking, as well as any prior imaging reports that describe a finding you are concerned about.

By signing below, I certify that I have adhered to all of the above instructions, and I understand that if I have not, it can render inaccurate test results with no fault to the technician or Midwest Thermography.

Patient's (Guardian's) Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's (Guardian's) Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Medical Thermal Imaging Consent

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

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

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Referred By: \_\_\_\_\_

I am a patient of Dr. Diane Diehn or Dr. Emily Guse and would like them to receive a copy of my report.

Please Mail a Copy to my Doctor or Healthcare Practitioner Listed Below:

(Please include Street Address, Suite Number, City and State):

1) \_\_\_\_\_

2) \_\_\_\_\_

I understand that I will be disrobed (from the waist up for breast exams, and underwear or shorts only for lower body exams) during part of the examination for both imaging and to allow for the surface temperature of my body to acclimate with the room. I have also been informed in advance that a female technician will be in the room to operate the thermal imaging camera. My body will be imaged with a digital infrared camera. I understand that this procedure does not use radiation. It is not harmful to me. Its sole function is to produce an image of the heat coming off my body. I also understand that a brief physical examination of any suspect areas found on the thermographic images may be performed in order to fully characterize the findings. Initial \_\_\_\_\_

Thermal imaging is a technology which measures the surface temperature of the body using infrared cameras and is analyzed to provide physiological information as an adjunct to standard screening and diagnostic testing. Initial \_\_\_\_\_

I understand that thermal imaging does not and cannot directly detect or be used to diagnose injury or disease of any kind and that the information is designed to be used with other examinations as an aid to the diagnostic process. Nor can it rule out the presence of injury or disease since some conditions do not produce sufficient temperature changes at the surface of the body to be seen with thermography. Therefore, injury or disease may still be present despite a lack of thermal findings present on examination. All concerns require evaluation by a doctor regardless of the thermal imaging results. Use of thermography as a stand-alone detection examination is not recommended as it can result in the failure of an existing condition to be detected. Initial \_\_\_\_\_

I further understand that not all organ systems, dental conditions, and medical conditions will produce thermal findings that will enable detection. Therefore, I understand that this test cannot determine if an organ or the body is diseased or healthy and it cannot diagnose disease. It is a functional test which may provide general regions to evaluate more thoroughly by a health care provider. It cannot replace or rule out the need for examination or additional testing. Initial \_\_\_\_\_

I confirm that I have followed the written pre-examination protocols for thermal imaging provided to me before the examination. I understand that if I did not receive and follow these protocols, the accuracy of my examination may be compromised. Initial \_\_\_\_\_

By signing below, I hereby acknowledge that (1) I have read and understood each of the above paragraphs; (2) I have had an opportunity to ask any questions I may have had; (3) any questions I asked were answered to my satisfaction; (4) I have received sufficient information with respect to thermal imaging to make an informed decision to undergo the procedure; (5) I understand no guarantee or warranty is being made that all risk for current and/or future injury or disease will be detected; and (6) I hereby authorize and consent to thermal imaging.

Patient's (Guardian's) Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's (Guardian's) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Cranial Health History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Scan: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: F  M  Initial Exam  Follow-up Exam

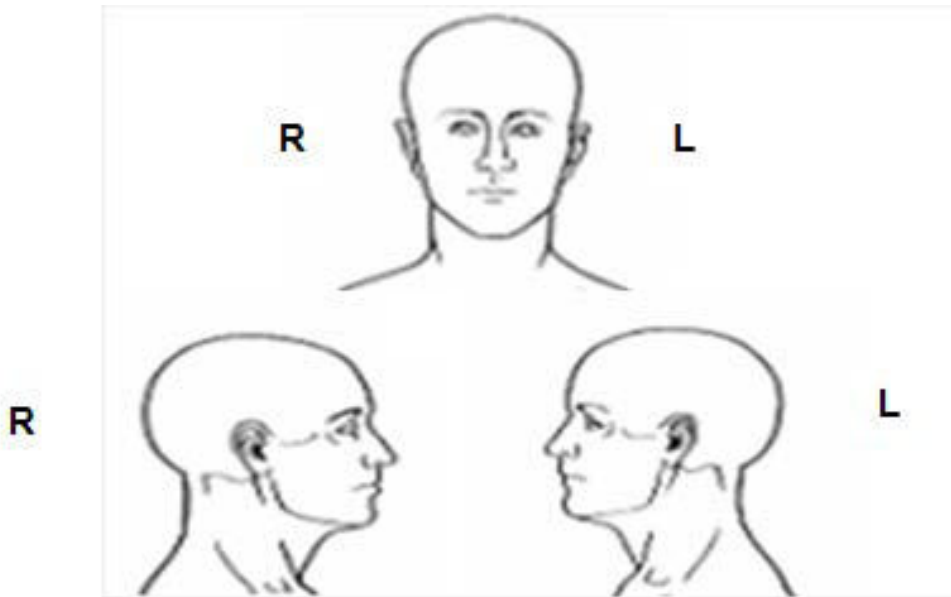
Please describe any current concerns with:

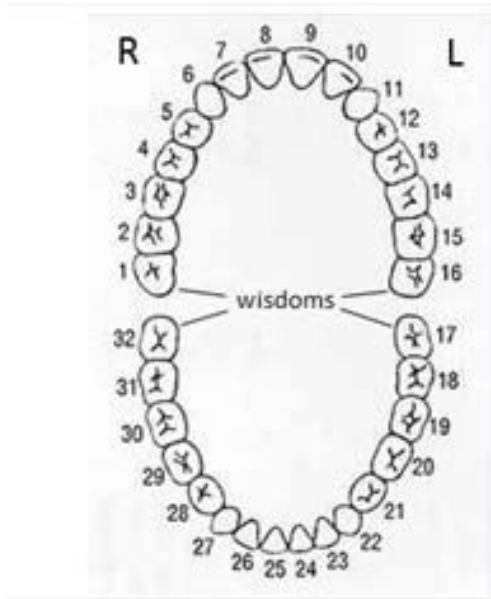
## Face and Anterior neck:

- Facial Pain
- Facial Numbing
- Tooth/Tooth Socket Pain
- TMJ Pain or Clicking
- Sinus Concerns
- Allergies
- Thyroid
- Lymph Node
- Headaches

Please Describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Place an "x" on the diagram in the area of concern.





History of:  None

Stroke

Cardiovascular Disease

Dizziness

Fainting

Please Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

History of: Root Canal  Yes  No

Wisdom Tooth Extraction  Yes  No

Please Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please do not write in this section**

Tech \_\_\_\_\_

Patient T = \_\_\_\_\_ F

Laboratory Temperature \_\_\_\_\_ C

**Additional Technician Notes**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## **INFORMED CONSENT FOR TESTING PROCEDURE**

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I further understand that not all dental, thyroid, and other conditions of the head and neck will produce thermal findings that will enable detection. Therefore I understand that this test cannot determine if these structures are diseased or healthy and it cannot diagnose disease. It is a functional test which may provide general regions to evaluate more thoroughly by a health care provider. It cannot replace or rule out the need for examination or additional testing. Initial \_\_\_\_\_

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\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **STATEMENT OF INDEPENDENT OPERATIONS:**

I understand and agree that Robert L. Kane, D.C., D.A.B.C.T., dba Kane Thermal Imaging Interpretive Services (collectively referred to as "Kane Interpretive Services") is a California based company that contracts with the provider of your imaging services solely for the purpose of interpreting and reporting thermal imaging scans. Your provider is not an employee, officer, director, partner, representative or agent of Kane Interpretive Services. Nor is Kane Interpretive Services an employee, officer, director, partner, representative or agent of your provider. Kane Interpretive Services is a wholly separate business entity from your provider and does not oversee or supervise your provider's thermography operations. Kane Interpretive Services is not involved in the design, manufacture, marketing, sale, rental, distribution, installation, inspection, repair or modification of any machinery or products used by your provider. Rather, Kane Interpretive Services is an independent contractor hired by your provider solely to interpret thermal imaging data and to report the results. Kane Thermal Interpretive Services does not control, nor have the right to control, your provider's business, including its equipment, operations, advertising and/or representations. Kane Interpretive Services makes no promises, warranties or representations, express or implied, as to your provider's services. In addition, Kane Interpretive Services owes no duty of care to me in connection with provider's services, including no duty to screen provider, no duty to protect or warn me of any actions or inactions of provider and no duty to investigate, communicate or mitigate any risks, known or unknown, relating to provider's services. I assume all duty of reasonable care to select, screen and monitor provider's services for my own safety and protection.

By signing this Statement of Independent Operations, I understand and agree with the foregoing and further agree that Dr. Robert L. Kane, D.C., D.A.B.C.T., dba Kane Thermal Imaging Interpretive Services is only responsible to me for the content of the thermal imaging report and its accompanying reporting guide.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

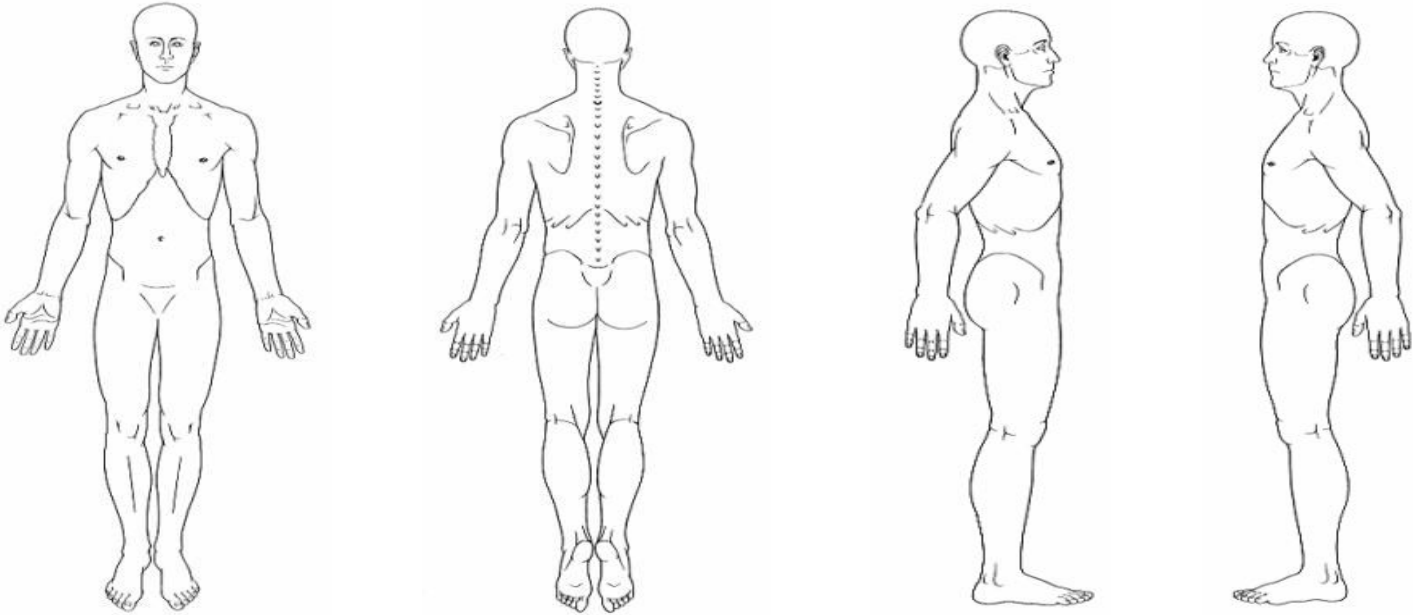
\_\_\_\_\_  
Date

# Full Body and Pain History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Scan: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: F  M  Initial Exam:  Follow-up Exam

Mark the location of symptoms with an "X" and label it as sharp, dull, burning, aching, etc.



### Please Note Level of Pain

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10  
**Mild: Annoyance**                      **Moderate: Some Limitations**                      **Severe: Pain Killers Needed**

Describe your symptoms: \_\_\_\_\_

\_\_\_\_\_

How and when did this start? \_\_\_\_\_

\_\_\_\_\_

Were you examined for this complaint? Date and Results \_\_\_\_\_

\_\_\_\_\_

What increases your symptoms? \_\_\_\_\_

\_\_\_\_\_



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