Integrative Medical Specialists, LLC®
Trusted Partners in Alternative Care

REGULATION THERMOMETRY PREPARATION INSTRUCTIONS

NAME _____ **DOB**_____ **CHART ID** _____

Body Temperature _____ Room Temperature _____ Technician _____

Welcome to Integrative Medical Specialists. Before you arrive for your regulation thermometry examination, certain protocols must be followed in order to ensure that your images reflect accurate information. Please check each box confirming the following instructions have been followed.

For 24-36 Hours *Prior* to Your Appointment - Observe the Following Instructions

_____ Avoid sunbathing, artificial tanning, waxing and laser treatments to the areas being tested. 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.

_____ Avoid taking supplements, vitamins, minerals or homeopathics within 36 hours prior to the test. If not contraindicated by your doctor, avoid taking pain medications or vasoactive drugs the day of the exam. Continue taking prescription medications, thyroid medication/supplements and hormones.

_____ Allow a minimum of 4-6 weeks after biopsy and 3 months after radiation prior to the test. Elevated temperatures can still be detected from tissue healing up to a year after a lumpectomy or mastectomy.

_____ For menstruating women, avoid testing the first or second day of the menstrual period as the lower abdominal points warm up and create false readings.

_____ Please reschedule your appointment if you have a fever, severe congestion or cough.

_____ Refrain from dentistry and dental cleanings at least 3 days prior to the test.

_____ No regulative and therapeutic practices within 36 hours prior to the test. This includes chiropractic, acupuncture, massage, physical stimulation, sexual activity, bio-energetic treatments, classical homeopathy, essential oils (topical or diffused), TENS, physical therapy, electrical muscle stimulation, ultrasound, IV therapy, ozone therapy, injectable therapies, sauna, hot tub, hot or cold pack use.

_____ No Mammography, CT scan, MRI or X-Ray within 3 days prior to the test.

_____ Do not drink alcohol for at least 24 hours prior to the test.

_____ Avoid shaving the upper body and face 24 hours prior to the test. Shaving the underarms is allowed.

_____ For men with beards or facial hair, please shave or trim as short as possible as multiple points are tested on the face, especially for the dental portion of the exam.

On The *Day* of Your Exam - Before You Arrive

_____ No exercise the morning of the test (running, yoga, Pilates, etc.)

_____ On the day of the test, skin must be free of deodorants (including natural deodorants), antiperspirants, lotions, oils, creams (including hormone creams), powders, perfume, body sprays, makeup, cosmetics or anything topical on the areas being tested.

_____ Do not drink coffee, black tea, or caffeinated beverages. Do not smoke the morning of the test. A light breakfast is acceptable, but nothing piping hot.

_____ No bathing or showering the day of the test. Bathing or showering is acceptable the night before the test.

_____ Come to the appointment hydrated; drink 12-16 ounces of water, 30 minutes to 2 hours prior to the test.

_____ 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_____

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The Whole Body Thermometry Testing Process

_____ Bring shoes, socks and comfortable, long pants that have a waistband that can easily be moved or folded down to allow for testing of points on the pelvic area.

_____ Prior to the test, the patient will sit for a 15 minute rest period so that the body has a chance to relax before testing.

_____ During the rest period the patient will also remove glasses, as there are sinus points on the nose that will be tested.

_____ Turn off cell phones and electronic devices during the appointment as the electromagnetic radiation from these devices affect the nervous system.

_____ Testing must be done no later than 2:00 pm.

The overall experience is safe, pleasant and relaxing for the patient. There is no harmful radiation, pain, or confined spaces. To ensure accurate test results, the imaging room is a constant controlled temperature at 70 degrees Fahrenheit (21 degrees Celsius.) The total process takes about 20 minutes.

A female nurse or medical assistant who is a certified thermographic technician will perform the test. The patient will stand, while wearing a robe and long pants or long skirt and socks, as the first set of measurements are taken. The patient will then disrobe and wear a spa wrap around the waist while standing for a ten-minute cooling period before the points are measured a second time. The test data is then computed by the system and the results are reviewed during a consultation with a doctor at Integrative Medical Specialists.

Cancellation Policy

- ✓ In order to provide excellent customer service, we strive to operate with efficiency. Our goal is to run on time for all our patient's appointments. **We request that all patients arrive at least 15 minutes prior to their scheduled appointment time.** This allows us to get any paperwork, updated information and test results organized and ready for your visit. If you are running late for your appointment, please call to see if we can accommodate a later appointment time. Out of respect for other patients, we may have to reschedule your appointment.

- ✓ Integrative Medical Specialists has a 24-hour cancellation/reschedule policy. Appointments cancelled without a 24 hour notice will be charged a $75.00 fee.

Other General Information

- ✓ We accept Visa, Mastercard, American Express, Discover and cash. We do not accept checks. Regulation thermometry is not covered by insurance. Payment is due at the time of service.
- ✓ A consultation with a doctor at IMS is required to review this data. The costs for the doctor's consultation is separate from the testing fee. Reports will not be given prior to the doctor's consultation.

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 Integrative Medical Specialists.

Signed (Patient/Guardian Name) _____ Date _____

Patient Name (Print) _____ Date _____

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REGULATION THERMOMETRY PATIENT CONSENT

PATIENT NAME _____ **DATE** _____

☐ Male ☐ Female Date of Birth _____/_____/_____

Specify the approximate date and location of any thermograms you've had before.

_____

_____

Specify any hospitalizations, illness, implants or surgery, and any complications you may have had.

_____

_____

_____

Specify the location of any scars you have.

_____

_____

Specify any bodily injuries you have had from a motor vehicle or other accident and when.

_____

_____

Specify any conditions you may have or had related to a specific organ of the body (e.g., heart , lungs, uterus, prostate, etc.).

_____

_____

_____

List Allergies to any medications._____

☐ I have received chemo or radiation. When? _____

Please list any current symptoms, medical conditions, or health concerns you may have:

_____

_____

_____

_____

MALES & FEMALES

Weight:_____ Height: _____ ☐ I am a smoker ☐ I smoked in the past 24 hours.

Within the past year, I have experienced the following (check all that apply):

☐ Digestive problems	☐ Eczema/hives/acne	☐ Joint Pain
☐ Vision/hearing	☐ Blood Pressure ☐ High ☐ Low	☐ Palpitations
☐ Sore muscles	☐ Shortness of breath/asthma	☐ Yeast Infections
☐ Low back pain	☐ Blackouts/Fainting	☐ Chronic Fatigue
☐ Urination problems	☐ Headaches/migraine	☐ Other _____

☐ I am currently taking medications: Details: _____

☐ I still have my tonsils ☐ I still have my appendix ☐ I still have my gall bladder

☐ I have my wisdom teeth.

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MALES & FEMALES

☐ I have dentures. ☐ Upper ☐ Lower ☐ Missing Teeth: Which teeth? _____

☐ I have a bridge or capped teeth. Which teeth? _____

☐ I have root canal teeth. Describe problems you may have had: _____

☐ I have silver amalgam fillings (dark or metal colored fillings).

☐ I consume alcohol: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

☐ I consumed alcohol or taken recreational drugs in the past 24 hours. Details: _____

☐ I have had "recent" emotional upsets or traumas in my life. Details: _____

☐ I ate a light breakfast.

☐ I had caffeine this morning.

☐ I slept well last night. I woke up today at: _____

☐ I am taking hormones: Details: _____ Oral Contraceptives: _____

☐ I have had hepatitis. Specify type: _____

FEMALES ONLY

Bra Size _____

☐ I am a new mother and currently nursing my child.

☐ I have a menstrual period. Indicate what day of your 28-day cycle you are in. _____

☐ I do not have a menstrual period ☐ I have had a total hysterectomy ☐ I have had a partial hysterectomy

☐ I have menstrual problems. Details: _____

☐ I am experiencing breast tenderness, discharge, etc. Details: _____

✓ I understand that the AlfaSight 9000® System is not a primary diagnostic device as deemed by the U.S. Food and Drug Administration. Its purpose is to provide additional information for the doctor to aid in the integration of other tests and results in order to achieve better treatment outcomes. It is not intended as a sole diagnostic method for any disease or dysfunction. *Initial* _____

✓ I understand that thermometry does not and cannot directly detect or be used to diagnose cancer. Nor can it rule out the presence of cancer. Thermometry does not replace any other examination. Health concerns and symptoms require evaluation by a medical doctor regardless of the thermometry results. Use of thermometry as a stand-alone detection examination is not recommended as it can result in the failure of an existing cancer to be detected. *Initial* _____

✓ I have requested and do hereby authorize Integrative Medical Specialists, LLC. (IMS) or any qualified and certified agents, independent contractors, or trainees of the Computerized Regulation Thermography (Alfa Sight 9000) System to perform an adjunctive diagnostic screening test with the Alfa Sight 9000 for the sole purpose of information only. I understand that the test data or readings from this procedure will be classified and categorized by an independent party familiar with the Alfa Sight 9000 and the data will be reviewed by a doctor at IMS for interpretation. *Initial* _____

✓ I understand that a consultation with a doctor at IMS is required to review this data. The costs for the doctor's consultation is separate from the testing fee. Reports will not be given prior to the doctor's consultation. I understand that I am ultimately responsible for payment to IMS and accept that regulation thermometry is not covered by insurance. Payment is due at the time of service. Health savings or flex spending plans may also be used for payment. *Initial* _____

✓ I confirm that I have followed the written pre-examination protocols for Whole Body Thermometry provided to me before the examination. I understand that if I did not receive or 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 Whole Body Thermometry 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; (6) I agree to indemnify and hold Alfa Thermodiagnostics and/or Integrative Medical Specialists, LLC. harmless for any decisions or actions I may make based on the results obtained; (7) I hereby authorize and consent to Whole Body Thermometry testing. *Initial* _____

Signed (Patient/Guardian Name) _____ Date _____

Patient Name (Print) _____ Date _____

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