

Core Care Center

Cindy Crawford, AMIA Board Qualified Thermographic Technician
1634 Union Street (@ Gough), San Francisco, CA 94123
415/928.8501
<http://www.CoreCareCenter.com>

Welcome!

Please fill out this form prior to your appointment.

Name / Date:	
Street Address:	
City, State, Zip:	
Date of Birth:	
Phone Home:	
Phone Work:	
Phone Cell:	
Fax (Hm or Wk?):	
Email:	
Website:	
Referred by:	
Alternate Contact Person (name, number, relationship to you):	
Goals with Appointment:	
Health Concerns or Injuries that bring you in: (How long has the problem existed)	
Medications / Supplements:	
Prior Treatments / Diagnosis:	

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During our consultation, we will determine which services we can provide you that match your goals and will put together a custom protocol that best suits your needs.

The next step may include one or more of the following assessment options:

- Consultation with Marc Weill for structural or nutritional analysis
- Consultation with Todd Barrett for nutritional analysis or machine therapy
- Thermography for determining inflammation or circulation issues
- Vega Testing for biological assessment
- Kinesiology or muscle testing
- Fingerstick test for lipid profile with TC and glucose, ALT-AST or hs-CRP

Then, your therapy options may include one or more of the following:

- Roling / Massage
- Dietary and Supplementary Protocol
- Photonic Stimulator for inflammation, pain and nerve repolarization
- Light Beam Generator or ST-8 for lymph movement
- O² Therapy
- MRT for detoxification
- Vega Select for homeopathic and energetic rebalancing
- EB-305 for detoxification and pH balancing

Please advise us if you have any of the following:

- A history of epilepsy or diabetes
- A pacemaker or other form of medically necessary electrical implant
- A known thrombosis
- Thyroid hyperactivity
- Asthma
- If you are pregnant, or are taking blood-thinning medication

All information shall remain confidential.

If you need to cancel your appointment with us, we require that you do so by speaking to our front desk staff directly (not via voicemail) up to 24 hours before your scheduled time. If we do not receive 24 hours notice, you will be charged the full amount of the scheduled session.

Payment is due at time of appointment for all services and products.

Disclaimer

Please be advised that the purpose of what we do, including nutritional supplementation and the other forms of therapy we offer, is to help restore biological and physiological equilibrium, and not meant to constitute primary care. We are not licensed to practice medicine, and cannot diagnose or treat disease.

Date: _____ Signature: _____

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Breast Screening with Infrared Thermal Imaging

What to Do Before Your Scan:

Complete all paperwork prior to your arrival. If this is not possible, arrive fifteen minutes early for your appointment and complete the necessary paperwork at that time. If you have questions, call the office at 415/928.8501. All information is confidential and is used by the physician to evaluate your thermal images.

- An exam should not be done on the first day of your period
- Avoid a hot shower at least 4 hours prior to exam
- Do not smoke for 2 hours before exam
- Do not use lotions or powder on your breasts on the day of the exam
- Avoid application of deodorant or antiperspirant (even crystal deodorant) if possible
- Avoid coffee or tea, hot or cold for 4 hours before exam – no caffeine
- Do not shave on the day of the exam to avoid skin abrasions
- Avoid sun exposure for extended periods of time the day before and on the day of the exam -- no sunburns
- No heated seats on the way to exam, or hot liquids
- Please provide a list of medications either prior to or at the time of the exam
- Notify the technician if you are taking Beta Blockers

For the exam, you will need to disrobe from the waist up and acclimate to room temperature (68°) for fifteen minutes prior to your scan. The scan will take approximately thirty minutes. If you are disabled or unable to sit or stand for long period, notify the scheduling technician. Complete testing requires your cooperation to image all areas affected. If you have any questions or concerns, please let us know beforehand if possible so that we may address them with you.

A "stress test" is usually included in your procedure. This involves chilling the hands or feet to produce a physiological response. This helps to provide additional information to the physician who will read your scan.

Test Results:

Once your scan is complete, it will take approximately two weeks before your results will be available. We will call you with the results and mail you a copy of the information.

Your scan results will include a recall period from six weeks to twelve months.

You are welcome to bring a companion or partner to be present during the exam. It is non-invasive and non-contact. The total time necessary to complete the procedure is approximately forty-five minutes to an hour.

Infrared imaging increases the chance of early detection of breast disease. Like all procedures, it is not a guarantee of detection. A complete program of breast health includes: Monthly self-exam, annual physician exam, annual thermal imaging and mammography as indicated (with an initial baseline at forty years of age). Ask your healthcare provider for additional information.

Client Signature: _____ Date: _____

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Release for Testing Procedure

Infrared Imaging is a non-contact, non-invasive test that demonstrates physiological patterns of your body. It is not a stand-alone diagnostic test. The information provided by your thermal scan is combined with your history to enable your health care provider to plan an approach to your care.

A licensed medical practitioner is the only qualified person to formulate a diagnosis. He or she must combine thermographic studies with your additional clinical and testing information to determine your problem. Infrared scans provide evidence of thermal asymmetries that may be present. An asymmetry may be indicative of a vascular, neurological, muscular or other physiological problem.

I have read the above information and I understand that I am not receiving a diagnosis of any condition based solely on my thermal scan. I understand that a thermal scan is non-invasive, and I reading the thermal patterns on the surface of my body. From this information a qualified practitioner will interpret any thermal abnormality displayed.

I am aware that my insurance provider may not reimburse me for the cost of this test. I understand that I am required to pay for this exam at the time of testing.

RECORD RELEASE

I authorize this clinic to release information regarding my scans, or to send copies to the following physicians:

Dr. William Cockburn, P.O. Box 2382, Whittier, California, 90610-2382

Client Name: _____

Signature: _____

Date: _____

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Thermal Image Analysis

Dr. William Cockburn, DC, FIACT, FABFE
Fellow in Thermal Imaging
PO Box 2382 Whittier, California 90610-2382
Voice: (562) 699-7921 Secure Fax: (562) 695-2439
<http://www.breastthermography.org>
docbill@earthlink.net

HIPAA Compliance Authorization of Electronic Transmission of Medical Data

I, the undersigned client, hereby authorize the transmission of my medical thermography examination and corresponding health information to Thermal Imaging Analysis and Dr. William Cockburn or his designated recipient for Interpretation and Report AND for the electronic return of this examination and its report to the laboratory or technician or physician's office who has performed the procedure.

I acknowledge that every attempt is being made by the designated lab and Thermal Image Analysis to comply with the Health Insurance Portability and Accountability Act (HIPPA) the primary goal of this form being to notify me of the actions being taken to protect my personal health information at both ends of this transmission.

I am advised via this form, that 1) the transmission of this data is being sent via 128 bit encryption software, 2) the medical data and personal health information being transmitted and received (at both ends) uses proprietary software coding only available to thermography labs and interpretation services whom I have issued to allow the access of my personal health information and 3) that special sentinel keys have also been used to single users so that no other party can access the software which will open my personal health information without legal authorization.

Every effort will be made to protect your medical records and personal health information.

I understand the above description of how my medical records and personal health information will be transmitted and handled by the parties at each end of the electronic transaction and further agree that this form and any attachments thereto may be faxed to the secure fax of the thermal image analysis, acting as a consent to read and report on thermographic examination.

Client Name: _____

Signature: _____

Date: _____

For Thermography Laboratory Use Only

Name of Lab Sending this Authorization: Core Care Center

Name of Authorized Individual Sending This Form: Cindy Crawford

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BREAST HEALTH QUESTIONNAIRE

FIRST NAME _____ LAST NAME _____ DOB ___/___/19__ Age _____
 ADDRESS _____ CITY _____ ST ___ ZIP _____
 Phone Number _____ Fax Number _____

MEDICATIONS Have you ever taken BC pills: Yes ___ No ___ Age started ___ Years taken _____
 Are you currently taking Birth Control Pills: Yes ___ No ___
 Birth Control pills taken before 1st pregnancy: Yes ___ No ___
 Estrogen Yes ___ No ___ Name of Estrogen taken _____ Years taken _____
 Progesterone Yes ___ No ___ Age started ___ Years taken _____ Currently taking Yes ___ No ___
 Name (type) of Progesterone: Prescriptive ___ Natural ___ Oral ___ Cream _____
 Other drugs: List (i.e. blood pressure medication, etc.) _____
 List supplements _____

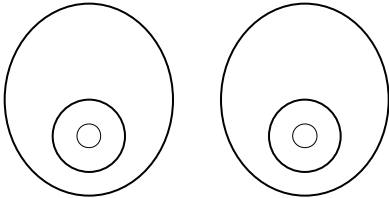
RELEVANT HISTORY

GENERAL INFORMATION TO CALCULATE RISK INDEX
 Menstrual day no. _____ Total days in cycle _____ Age Started _____
 Menopause age started: _____ Hysterectomy: Yes ___ No ___ Age _____ Ovaries removed: Age _____ Ovary R ___ L ___
 No. of Pregnancies ___ Age at 1st Preg. ___ No. of Live Births ___ No. of children nursed more than 1 mo. ___
 Are you Caucasian ___ African American ___ Asian American ___ Native American ___ Jewish ___ Other _____
 LBS Overweight : 1 -20 lbs ___ 20— 40 lbs ___ 40 – 60 lbs ___ 60 + lbs ___
 Have you experienced ANY blunt trauma to the chest: Yes ___ No ___ Year _____
 Do you consistently use anti-perspirants ? _____
 FAMILY HISTORY OF BREAST CANCER
 Self ___ age ___ Mother ___ Sister ___ Daughter _____
 Maternal grandmother _____ Maternal aunt _____ Maternal cousin _____
 Paternal grandmother _____, Paternal aunt _____, Paternal cousin _____
 Date of last thermal image _____ Date of last mammography exam _____ Date of last breast ultrasound _____
 Normal ___ Abnormal ___ Normal ___ Abnormal ___ Normal ___ Abnormal ___
 Room Temperature _____ Client Temperature _____

NOTES

Physical Exam: Note by letter on the diagram the region of the breasts if affected by any of the following:

- | | | |
|------------------------|----------------------|-----------------------|
| A Mass | B Thickening | C Discharge |
| D Nipple Change | E Skin change | F Area of pain |
| G Burning | H Tender | I Dull ache |
| J Sharp pain | K Implants | |



Have you ever had a biopsy: Yes ___ No ___ How many _____
 Needle biopsy ___ Surgical biopsy ___ L ___ R ___ Position _____ Year _____
 Were you told is was: Benign ___ Suspicious ___ Malignant ___
 Lumpectomy : Yes ___ No ___ R _____ L _____ Year of surgery _____
 Mastectomy: Yes ___ No ___ R _____ L _____ Year of surgery _____
 Radiation to breast: Yes ___ No ___ R _____ L _____ Month: _____
 Year: _____
 Chemotherapy: Yes ___ No ___ Month: _____ Year: _____

The information supplied is, to my knowledge, true and complete.

Patient's Name : _____
 Signed : _____ Technician Initial _____
 Date : _____ Date: _____