LifeStream Health Centre
Patient Consent for Diagnostic Screening with Alfa Sight 9000

I have requested and do hereby authorize LifeStream Health Centre or any qualified and certified agents, independent contractors, or trainees of the Computerized Regulation Thermography (Alfa Sight 9000) System to perform 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 forwarded to my chosen medical professional for interpretation and medical care intervention. **Regulation Thermography is an adjunctive NOT primary diagnostic tool. I am responsible for following up with medical care with my health care practitioner and should not rely on this procedure for the diagnosis or treatment of any medical condition.**

I certify that I have consulted with a representative of LifeStream Health Centre and have read all applicable literature given to me. I have read and fully understand all of the information presented in this Patient Consent and Release form for Diagnostic Screening. I accept the explanation of my responsibility for following up with a health care professional of my choosing and understand that the diagnostic screening test data will not be mailed directly to me but directly to my medical professional I designate on my intake forms. I certify that I am eighteen (18) years of age or older, of sound mind, and I am fully capable of executing this Patient Consent and Release form for Diagnostic Screening myself.

*NAME:*_____

*DATE OF BIRTH:*_____

*TEXAS DRIVERS LICENSE NO:*_____

*SIGNATURE*_____ *DATE:*_____

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT *Date_____*

Name_____Home phone_____

Address_____Work phone_____

City_____State_____Zip_____Cell phone_____

Male_____Female_____ Birthdate_____Email_____

Marital status_____Number of children_____Name of Spouse_____

Occupation_____Employer_____

Incase of emergency notify_____Phone_____

Have you had a thermogram before?_____ Date/location_____

List hospitalizations, illness, implants or surgery and any complications
_____

Do you still have your tonsils?_____Appendix?_____Gallbladder_____

Do you have any scars?(note location)_____

Have you had any motor vehicle or other accidents that caused bodily injury? Where in the body & when?_____

Do you have now or have had any conditions related to a specific organ of the body re: heart, lungs uterus, prostate, etc?_____

Within the past year have you experience ANY of the following?

Digestive problems	*Joint pain*	*Eczema hives acne*
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_____*

Have you had hepatitis?Type_____
List allergies to any medications?_____
Have you received chemo or radiation?_____If so when?_____

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

1._____

2._____

3._____

4._____

5._____

6._____

FEMALES ONLY
What day of 28 day cycle are you in?_____I do not have a menstrual period
I had a hysterectomy?_____Do you have menstrual problems?_____
Describe_____
Are you experiencing any breast tenderness or discharge etc?_____
Bra Size_____Cup Size_____

MALES AND FEMALES

Weight_____Height_____Do you smoke?_____

List any hormones you currently take_____Oral contraceptives_____

What medications are you currently taking?_____

Do you have dentures?_____Upper_____Lower_____Missing teeth?___

Do you have a bridge or capped teeth?_____Which teeth?_____

Do you have root canal teeth?_____Problems with root canals_____

Do you have silver amalgam fillings(dark or metal colored fillings) Yes or No

Do you have your wisdom teeth?_____

Consume Alcohol? Daily_____Weekly_____Monthly_____Rarely_____

Have you consumed any alcohol or taken recreational drugs in the past 24 hours?____

Have you had any emotional upsets or traumas in your life "Recently"?_____

Have you smoked in the past 24 hours?_____

Did you eat a light breakfast?_____Did you have caffeine this morning?_____
For new mothers: Are you currently nursing your child?_____

Did you get a good nights sleep?_____What time did you get up today?_____

I understand that LifeStream Thermography is not a primary diagnostic device as deemed by the US Food and Drug Administration. Its purpose is to add information to the health practitioners to aid in the integration of other tests and results in order to achieve treatment outcomes, and not intended as diagnostic of any disease or dysfunction in itself. I agree to not hold LifeStream Health Centre responsible for any decision I or my practitioner make based on the results obtained.

Signed (Your Name)_____Date_____

Please send my report to my health care practitioner (please fill in all information possible)

Practitioners Name_____Title_____

Work Phone_____Fax_____

Address_____

City_____State_____Zip_____

Who referred you?_____

I understand that this thermogram in and of itself is simply an additional device to evaluate the balance and health of my body and is not to exclude other methodologies of cancer detection. I am ultimately responsible for payment to LifeStream Health Center. Payment is due at the time of service. You will be given a receipt for your visit, which you can submit to your insurance company. If the insurance company does not pay for the services. LifeStream assumes no responsibility for reimbursement.

Signed_____Date_____