Holistic Hub Renew Your Health with US	HOLISTIC HUB LLC PATIENT GUIDELINES	Jodi Quibell CCT 1425 South Columbia Road, Grand Forks, ND 58201 Office (701) 330-1151

PURPOSE OF THERMOGRAPH:

For early detection of abnormal physiological changes in the breast, requiring further diagnostic testing. A screening baseline cannot be acquired while pregnant or lactating, (wait 3 months post lactation).

CLIENT PREPARATION:

Prior to your appointment DO NOT (on the day of):

1. Have a physical therapy electromyography.
2. Use a tanning booth, avoid over exposure to the sun.
3. Carry out strenuous exercise.
4. Smoke for 2 hours.
5. Shave under your arms, use lotions, powders, antiperspirants, therapeutic essential oils, or make up.
6. Do skin brushing.
7. Have kidney dialysis.
8. Body work **2 DAYS** prior.
9. Acupuncture treatment **3 DAYS** prior.
10. Lactation within last 3 months.
11. Let long hair fall below the neck.
12. Do not wear tight fitting clothes, jewelry around the neck

No changes are needed to your diet or medications.

GENERAL INFORMATION:

The **PROCEDURE** is non-invasive, non-contact, private, and no radiation used.

DISROBING will require you to remove all upper body clothing and jewelry. Put on a gown, which will be provided.

Inform your thermographer if you have had any recent skin lesions on the breast region. Inflammation may cause a false positive report.

Thermographs are always completed by a female "Certified Clinical

Thermographer". They are in complete privacy.

There are no risks or side effects.

The average time for an appointment is 30 minutes.

Please bring your healthcare provider's name and address if you want a copy of the report and scans sent to them. You will have to sign a release of information for this.

YOU ARE WELCOME TO BRING A COMPANION TO BE PRESENT AT THE SCAN, FOR YOUR COMFORT.

Holistic Hub Renew Your Health with US	HOLISTICHUBLLC PATIENTHISTORY	1425SouthColumbiaRoad, Grand Forks, ND 58201 Office (701) 3301-151

CLIENT NAME: **DOB:** **GENDER:** **DATE:**

1. PRIMARY CARE PHYSICIAN: _____
2. REFERRING PHYSICIAN: _____
3. CLINICAL CONCERNS: _____

   _____

   _____
4. CURRENT SYMPTOMS: _____

   _____

   _____
5. CURRENT TREATMENT: _____
6. CURRENT MEDICATION: _____
7. THERMOGRAM HISTORY: _____
8. RESULTS OF CLINICAL CORRELATION: _____
9. SURGICAL HISTORY: (indicate month/year): _____

   _____

   _____
10. DENTAL HISTORY: _____
11. GENERAL HISTORY: _____

    _____

    _____

12. FAMILY HEALTH HISTORY: (For example: Father: living at 83 years of age with High blood pressure, psoriasis, 2 heart attacks)

    Father:_____

    Mother:_____

    Maternal Grandfather:_____

    Maternal Grandmother:_____

    Paternal Grandfather: _____

    Paternal Grandmother: _____

    Brother(s):_____

    Sister(s):_____

13. DIAGNOSIS: (indicate month/year)_____

14. SKIN LESIONS OR PHYSICAL ABNORMALITIES: _____

_____

_____

FEMALE CLIENTS ONLY

1. OBGYN HISTORY: (indicate month/year)_____
2. MAMMOGRAM / ULTRASOUND HISTORY: (indicate month/year)_____
3. NOTES: _____

If more space is needed, please continue over the page

Holistic Hub Renew Your Health with US	HOLISTIC HUB LLC CONFIDENTIAL QUESTIONNAIRE	1425 South Columbia Road, Grand Forks, ND 58201 Office (701) 330-1151

CLIENT NAME: _____ **D.O.B:**_____ **GENDER:**_____ **DATE:**_____

EMAIL ADDRESS: _____ **PHONE NUMBER:**_____

1. Do you have any close relatives who have 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 on your breasts? YES / NO
5. Have you ever had any breast cosmetic surgeries or implants? YES / NO
6. Have you had a mammogram in the last 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 taken a contraceptive pill for more than 1 year? YES / NO
10. Have you suffered from cancer of the womb? YES / NO
11. Have you had pharmaceutical hormone replacement therapy? YES / NO
12. Do you have annual physical exams with the doctor? YES / NO
13. Do you perform a monthly breast self-exam? YES / NO
14. Did your periods start before the age of 12? YES / NO
15. Did your periods finish after the age of 50? YES / NO
16. Had a vaccination in the last 4 weeks? YES / NO
17. (If yes - which arm) Left arm _____ Right arm _____
18. Did you breastfeed any of your children? Yes_____ No _____ Attempted _____
19. How many mammograms have you had in total? _____

Holistic Hub Renew Your Health with US	HOLISTIC HUB LLC CONFIDENTIAL QUESTIONNAIRE	1425 South Columbia Road, Grand Forks, ND 58201 Office (701) 330-1151

20 . At what age did you have your first mammogram? _____

21. How many childbirths have you had? _____

22. How old were you at your first child's birth? _

23. Do you smoke? Yes ___ No ___ Never ___ Not in last 12 months ___ Not in last 5 years ___

24. Have you recently had any of these breast symptoms:

	Right Breast	Left Breast
Pain	_____	_____
Tenderness	_____	_____
Lumps	_____	_____
Change in breast size	_____	_____
Area of skin thickening or dimpling	_____	_____
Secretions of the nipple.	_____	_____

Holistic Hub Renew Your Health with US	HOLISTIC HUB LLC EXTENDED BREAST QUESTIONNAIRE	1425 South Columbia Road, Grand Forks, ND 58201 Office (701) 330-1151

CLIENT NAME: _____ **D.O.B.** _____ **DATE** _____

Diagnosed with breast cancer:

Cancer type: Metastatic _____ Local _____ Lymph node involvement _____

When diagnosed: Month _____ Year _____

Breast location: Refer to diagram below.

Left Breast: UO _____ UI _____ LO _____ LI _____ Nipple _____

Right Breast: UO _____ UI _____ LO _____ LI _____ Nipple _____

Treatment: Surgery _____ Chemo _____ Radiation _____ Other _____ None _____

Diagnosed with other breast disease:

Disease type: Fibrocystic _____ Cystic _____ Mastitis _____ Abscess _____ Other _____

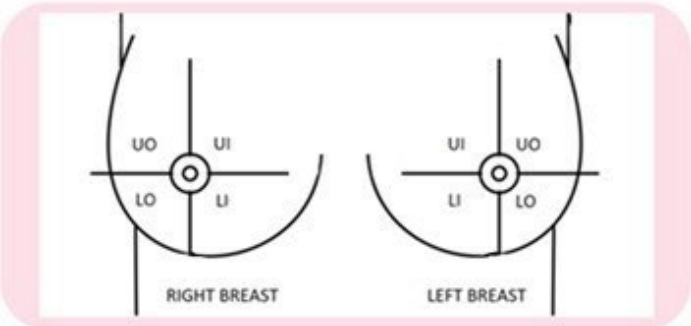
(Please report 'other types of diseases in your history)

Location of breast biopsies or surgeries: Refer to diagram below.

Left Breast: UO _____ UI _____ LO _____ LI _____ Nipple _____

Right Breast: UO _____ UI _____ LO _____ LI _____ Nipple _____

Breast Quadrants Map



Holistic Hub Renew Your Health with US	HOLISTIC HUB LLC FULL BODY PAIN QUESTIONNAIRE	1425 South Columbia Road, Grand Forks, ND 58201 Office (701) 330-1151

CLIENT NAME:_____ **DOB:**_____ **DATE:**_____

Please use the symbols below to indicate areas of:

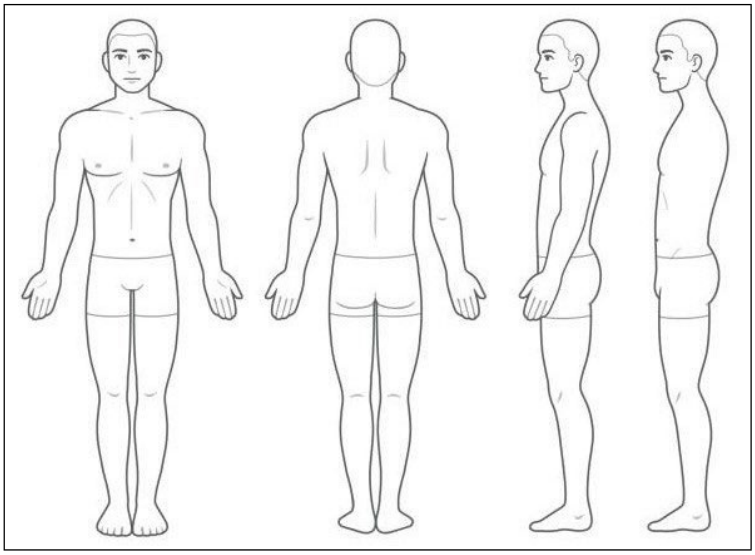
Main pain - 1

Secondary Pain – 2

Numbness - 3

Pins and needles - 4

Skin lesions and scarring; (Mark locations
They appear on your body) - 5



Do you know what triggered the pain?

_____

Does anything relieve it?

_____

Does anything aggravate it?

_____

Has it changed since it began?

_____

Have you had any treatment?

_____

Any other comments?

_____

REVIEWED FEBRUARY 2026 - SQ

	HOLISTIC HUB LLC PATIENT REVIEW OF BODY SYSTEMS	1425 South Columbia Road, Grand Forks, ND 58201 Office (701) 330-1151

CLIENT NAME: _____ **DOB:**_____ **DATE:**_____

Check all those that apply:

	Constitutional		**Dental**		**Skin**
	Fevers / Chills / Sweats		Extractions		Rash or mole
	Unexplained weight loss or gain		Crowns		
	Fatigue / Weakness		Root canal		**Neurological**
	Excessive thirst or urination		Gum Disease		Numbness
			Fillings		Headache
	Musculo – Skeletal		Other		
	Muscle / Joint pain				**Organ dysfunction**
			Respiratory		Liver / Gall bladder
	Ear / Nose / Throat		Cough / Wheeze		Spleen / Pancreas
	Difficulty Hearing / Ringing		Difficulty breathing		
	Hay Fever / Allergies				**Blood / Lymphatic**
			Gastrointestinal		Unexplained lumps
	Cardiovascular		Heartburn / Reflux		Easy bruising
	Chest pain / Discomfort		Nausea / Vomiting Diarrhea		
	Leg pain with exercise		Large bowel dysfunction		
	Palpitations		Abdominal pain		

General medical history: Past and current medical problems (Please add dates if known)

	Other		**Genitourinary**		**Other**
	Heart Disease: (Type)		Kidney / Bladder		High cholesterol
	Diabetes		Reproductive organs		Kidney disease
	Asthma / Lung disease		High blood pressure		Cancer (type)
	Accidents		Thyroid problem		
			Chemical exposure		

Holistic Hub Renew Your Health with US	HOLISTIC HUB LLC INFORMED CONSENT FORM	1425 South Columbia Road, Grand Forks, ND 58201 Office (701) 330-1151

CLIENT NAME:_____ **DOB:**_____ **DATE:**_____

Please read the following and sign below:

I understand that:

1. Holistic Hub LLC and its certified thermographer will use digital infrared Thermal imaging (DITI) to take images of specified region(s) of my body as requested.
2. These images may identify abnormal heat patterns indicating objectively the body's response to pain and dysfunction and may require further investigation.
3. These images will be interpreted by the medical staff at Electronic Medical Interpretation (EMI) inc. (Thermography group). The report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment and NOT intended for self-evaluation or self-diagnosis.
4. DITI is not a substitute for adequate medical care, and I intend to remain under care of my primary health care provider.
5. The report will not tell me whether I have any illness, disease, or condition, but will be an analysis of the images with respect only to the thermographic findings of the area(s) discussed in the report.
6. DITI is not a replacement for any anatomical imaging (mammogram/ultrasound/MRI).
7. I am responsible for my own decisions regarding my health, wellness and nutrition. Therefore, I hold Holistic Hub LLC, harmless as to the results and interpretations resulting from this process.
8. Holistic Hub LLC, will keep all information shared by me completely confidential unless I provide a release in writing or as required by law (HIPAA)

Acknowledgement:

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

Print name: D.O.B. Date:

_____
Client signature:

_____
Name and relationship if other than client:

	HOLISTIC HUB LLC AUTHORIATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION	1425 South Columbia Road, Grand Forks, ND 58201 Office (701) 330-1151

CLIENT NAME: _____ **DOB:** _____ **DATE:** _____

Address: _____

As required by the privacy regulations, Holistic Hub LLC. May not use or disclose your protected health information except as provided in our notice of privacy practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office.

EMI Thermography

Patient Health Information authorized to be disclosed: Thermal images and related health history.

For the specific purpose of: **Interpretation of said images.**

Effective date for the authorization: _____
This authorization will expire upon written request.

I understand that the information disclosed above may be re-disclosed to additional parties an no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed in this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature of Patient or Patient's Authorized Representative. Date.

_____ _____
Authorized signature of facility. Date.