719-339-0690
www.totalbodyworkspersonaltraining.com

Patient Intake Form

TODAY'S DATE:___/____/_____

PERSONAL INFORMATION

PATIENT'S NAME: _____

DATE OF BIRTH: _____ AGE: _____ SEX: M F

PARENT'S NAME: _____
(if applicable)

STREET ADDRESS: _____

CITY STATE ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ BUSINESS PHONE: _____

E-MAIL ADDRESS: _____

MARITAL STATUS: Minor, Single, Married, Separated, Divorced, Widowed

EMPLOYMENT: Minor, Full-time, Part-time, Unemployed, Disabled, Retired

EMERGENCY CONTACT-

NAME: _____

DAYTIME PHONE: _____ RELATIONSHIP TO PATIENT: _____

STREET ADDRESS:_____

CITY, STATE, ZIP:_____

REFERRAL-

HOW DID YOU HEAR ABOUT OUR FACILITY? Friend/Family, Online, Other_____
WHO CAN WE THANK FOR YOUR REFERRAL?

E-MAIL ADDRESS, PHONE:_____

CURRENT HEALTH CONCERNS

Have you ever had, or do you currently have...?

Lung disease, any form Yes No >If Yes Explain and if treated, type _____

Emphysema
Pneumothorax/Collapsed Lung
Chest surgery
Heart failure
High Blood Pressure

Any electronically implanted medical device (i.e., pacemaker, deep brain stimulator) Any diseases or conditions involving ears or sinus or surgical interventions Difficulty in clearing ears during airplanes or pressurized environments like diving.

Claustrophobia
Epilepsy/Seizures
Diabetes
Cataracts

CONCERNS (PLEASE LIST IN ORDER OF PRIORITY) AND PREVIOUS TREATMENTS-

1. _____Previous treatments_____

2. _____Previous treatments_____

3. _____Previous treatments_____

4. _____Previous treatments_____

5. _____Previous treatments_____

PHYSICIAN

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? Yes No

DID THEY RECOMMEND HYPERBARIC OXYGEN THERAPY? Yes No

DO YOU HAVE A PRESCRIPTION FOR HYPERBARIC OXYGEN THERAPY? Yes No

PHYSICIAN'S NAME AND SPECIALTY: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ FAX: _____

SOCIAL HISTORY-

TOBACCO USE: Never, Previously-but Quit, Currently > IF YES, # PACKS/DAY:_____

CAFFEINE USE: Never, Yes > IF YES, LIST FREQUENCY & SOURCE OF CAFFEINE: _____

ALCOHOL USE: Never, Rarely, Moderately, Daily

DRUG USE: Never, Yes > IF YES, LIST FREQUENCY & TYPE OF DRUG USE: _____

1. CURRENT MEDICATIONS (List all medicines you are currently taking including prescription and over-the-counter)

MEDICATION: _____ DOSAGE: _____ FREQUENCY:_____

MEDICATION: _____ DOSAGE: _____ FREQUENCY:_____

MEDICATION: _____ DOSAGE: _____ FREQUENCY:_____

MEDICATION: _____ DOSAGE: _____ FREQUENCY:_____

1. CURRENT MEDICATIONS (CONTINUED)-Please attach separate list if necessary-

2. ALLERGIES (please list all known allergies):_____

3. DIABETES-

DO YOU HAVE DIABETES? Yes No

> IF YES, DO YOU TAKE: insulin, oral agents, diet controlled

> IF YES, HOW OFTEN DO YOU TEST YOUR BLOOD SUGAR? _____ time(s)/day

4. PULMONARY LUNG DIAGNOSIS
HAVE YOU EVER BEEN DIAGNOSED WITH ANY LUNG / PULMONARY CONDITION, OR PULMONARY FIBROSIS? No Yes

> IF YES, WHAT IS THE CONDITION? _____

5. SEIZURE OR CONVULSION ACTIVITY
ARE YOU EXPERIENCING SEIZURES OR CONVULSIONS OR HAVE YOU BEEN TOLD THAT YOU ARE AT RISK FOR SEIZURES? No Yes

> IF YES, WHAT IS THE CONDITION(S)? _____

6. PREGNANCY STATUS
ARE YOU PREGNANT OR THINK YOU COULD BE? No Yes

7. EAR HISTORY
a) HAVE YOU EVER HAD EAR PROBLEMS? No Yes
b) DO YOU HAVE ANY PROBLEMS WITH YOUR EARS WHEN YOU FLY? No Yes
c) DO YOU HAVE ANY PROBLEMS GOING UP AND DOWN IN AN ELEVATOR? No Yes
d) DO YOU OR HAVE YOU EVER DONE SCUBA DIVING? No Yes
e) DO YOU KNOW HOW TO EQUALIZE PRESSURE IN YOUR EARS? No Yes

OTIC BAROTRAUMA: Is a condition of injury to the eardrum, and is extremely unlikely to occur in the hyperbaric chamber.

However, severe ear discomfort can be caused if you cannot equalize the pressure in your ears. As the chamber is pressurized and depressurized you must be able to equalize the pressure in your ears to acclimate to the pressure changes. You will most likely experience "popping" in your ears. While this is normal, you should not experience pain of any kind in the chamber.

You can assist the equalization process by yawning, swallowing, working your jaw side to side and up and down (chewing motion), turning the head side to side and ear to shoulder. Sitting upright in the chamber during pressurization and depressurization will generally also make the equalization process more comfortable. In general, whatever assists you being comfortable when taking off and landing in a plane may be most effective for you. Continue to do this as needed for the duration of pressurization and depressurization. When the chamber reaches full pressure and again when the chamber is completely deflated there should be no additional pressure in the ears.

IF YOU ARE UNABLE TO EQUALIZE EAR PRESSURE AND EXPERIENCE PAIN IN ONE OR BOTH EARS, COMMUNICATE ANY DISCOMFORT IMMEDIATELY TO THE STAFF.

This will give us the opportunity to make adjustments in the pressurization or depressurization process to eliminate discomfort.

8. MEDICAL IMPLANTS
DO YOU HAVE ANY IMPLANTED MEDICAL DEVICES? No Yes

> IF YES, PLEASE DESCRIBE THE DEVICE,
MANUFACTURER AND DATE IMPLANTED. _____

9. NUTRITION PROFILE
a) DO YOU HAVE DIFFICULTY CHEWING OR SWALLOWING? No Yes
b) DO YOU NEED ASSISTANCE FOR EATING? No Yes
c) HAVE YOU HAD A LARGE WEIGHT LOSS OR WEIGHT GAIN? No Yes

> IF YES: _____ lbs. _____ months

> IF YES,
REASON (IF KNOWN): _____

d) DO YOU HAVE A SPECIAL DIET? No Yes

> IF YES,
PLEASE EXPLAIN: _____

e) DO YOU HAVE ANY FOOD ALLERGIES OR SENSITIVITIES? No Yes

> IF YES,
PLEASE EXPLAIN: _____

f) ARE YOU INVOLVED IN A WEIGHT LOSS PROGRAM? No Yes

> IF YES,
PLEASE EXPLAIN: _____

g) HOW IS YOUR APPETITE? Good Fair Poor
h) HOW MUCH WATER DO YOU DRINK EACH DAY? _____ or _____ glasses

i) DO YOU EXERCISE REGULARLY? No Yes

> if YES,
HOW OFTEN: _____

j) DO YOU TAKE VITAMINS OR SUPPLEMENTS No Yes

> IF YES, LIST ALL VITAMINS AND/OR SUPPLEMENTS TAKEN.

SUPPLEMENT: _____ DOSAGE: _____ FREQUENCY: _____

SUPPLEMENT: _____ DOSAGE: _____ FREQUENCY: _____

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SUPPLEMENT: _____ DOSAGE: _____ FREQUENCY: _____

SUPPLEMENT: _____ DOSAGE: _____ FREQUENCY: _____

SUPPLEMENT: _____ DOSAGE: _____ FREQUENCY: _____

Hyperbaric Oxygen Therapy (HBOT), has been reported to have beneficial effects for a wide range of conditions, without many negative side effects that can be harmful to your health. Nevertheless, as with many treatments, there are areas of concern which you should be aware of. It is important that you take into account what you have read in the former pages and ask any questions that you may have before starting treatments.

I testify that the information I have provided is true and accurate to the best of my knowledge, and I have been explained the potential risks for any of the above questions that I answered "yes" to and have been given the opportunity to speak to my doctor or a healthcare provider about this.

Signature _____ Date_____