



CLIENT INTAKE FORM FOR HYPERBARIC ASSESSMENT

Today's date: dd / mm / yyyy

CLIENT INFORMATION

Mr. Miss Dr. male single married / common law
 Mrs. Ms. _____ female divorced separated widowed

Date of birth: dd / mm / yyyy

First name

Last name

Middle / initials

Occupation (past or present)

CONTACT INFORMATION

Email Contact Address (confidential):

Phone numbers (confidential): home / work / cell:

Street Address

City

Province
State

Postal code
Zip code

MEDICAL INFORMATION

Family physician (name / address / city / phone number)

Specialist you are seeing regularly (name / address / city / phone number)

Medication (prescribed and non-prescribed)

Primary reason for your visit today?

Past surgeries

Allergies

REFERRAL INFORMATION

Referring health care professional (name / city / address / phone number)

How did you hear about BaroMedical?

OVER ⇨

MEDICAL HISTORY

Do you exercise on a regular basis?

Yes No

If yes, how often: _____

Do you use:

Yes No

Tobacco
 Alcohol

Are you pregnant

Yes No

or suspect pregnancy?

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Acute Respiratory Illness	<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Mirtal valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	Frequently tired	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever / allergies	<input type="checkbox"/>	<input type="checkbox"/>	If so, when: _____		
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Chemical sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorders	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	Infections, frequent	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems / ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chronic fatigue syndrome (CFS)	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>			
Fainting / seizures	<input type="checkbox"/>	<input type="checkbox"/>	Lung infection, frequent	<input type="checkbox"/>	<input type="checkbox"/>			
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Malignant disease	<input type="checkbox"/>	<input type="checkbox"/>			

Do you have any ear problems?:

Yes No

Problems with your ears when flying
 Problems with your ears riding an elevator
 Problems with your ears going up or down mountains

Notes / comments:

CONSENT INFORMATION

I certify that I have read and understand the above information to the best of my knowledge and that the above questions have been accurately answered. I authorize the release of any medical information from my chart to any healthcare professionals who may be involved in my therapy. I understand it is my responsibility to update this information as needed. This includes changes in medical conditions / diagnosis, medications and personal and physician contact information. I agree to be responsible for payment of all services rendered on my or my dependents behalf.

Signature: _____

Date: _____

