



CLIENT INTAKE FORM FOR HYPERBARIC ASSESSMENT

Today's date: dd / mmm / yyyy

CLIENT INFORMATION

<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	<input type="checkbox"/> Dr.	<input type="checkbox"/> male	<input type="checkbox"/> single	<input type="checkbox"/> married / common law	Date of birth: dd / mmm / yyyy
<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	<input type="checkbox"/> _____	<input type="checkbox"/> female	<input type="checkbox"/> divorced	<input type="checkbox"/> separated <input type="checkbox"/> widowed	

First name

Last name

Middle / initials

Occupation (past or present)

CONTACT INFORMATION

Email Contact Address (confidential):

Consent to receive information emails:
 YES NO (default) - Initials: _____

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

Emergency Contact Number/Name:

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 <input type="checkbox"/> <input type="checkbox"/> If yes, how often: _____	Do you use: Yes No Tobacco <input type="checkbox"/> <input type="checkbox"/> Alcohol <input type="checkbox"/> <input type="checkbox"/>	Are you pregnant or suspect pregnancy? Yes No <input type="checkbox"/> <input type="checkbox"/>
---	--	--

Do you use any medical devices attached or implanted to or in your body:

Hearing aid
 Infusion pump
 Pacemaker
 Electrical stimulator
 Cochlear implant
 other battery operated devices

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"/>	Mitral 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"/>	Chest X-ray in the last 6 months	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Malignant disease	<input type="checkbox"/>	<input type="checkbox"/>	COVID positive test	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any ear problems?: Yes No Problems with your ears when flying <input type="checkbox"/> <input type="checkbox"/> Problems with your ears riding an elevator <input type="checkbox"/> <input type="checkbox"/> Problems with your ears going up or down mountains <input type="checkbox"/> <input type="checkbox"/>	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:** _____

