

**Hyperbaric Oxygen Therapy Intake**

**Today's Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**First Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle Initial** \_\_\_\_ **Last Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Suffix (Jr. Sr. III)** \_\_\_\_\_\_ **Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**\_\_\_\_\_\_\_ **Zip** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Work Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile Phone \_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_

**Best Contact Method:** \_\_\_ **Primary Phone** \_\_\_ **Work Phone** \_\_\_ **Mobile Phone**

**EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age** \_\_\_\_\_\_ **Marital Status** (check one) \_\_\_\_ **Single** \_\_\_\_ **Married** \_\_\_\_**Other**

**Emergency Contact's Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your main complaint today that you wish to seek treatment for?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

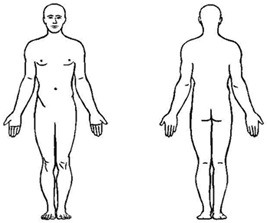
When did your symptoms start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a **NEW** complaint? ☐ Yes ☐ No If a **NEW** complaint, please explain the incident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your symptoms interfering with your: Work\_\_\_ Daily routine\_\_\_ Sleep\_\_\_ All\_\_\_

What activities worsen your symptoms?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities improve your symptoms?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your symptoms getting progressively worse? Yes\_\_\_\_ No \_\_\_\_

**Mark an X on the diagram where you are experiencing your symptoms:**

**If** your complaint involves pain, please characterize type:

☐ Constant ☐ Intermittent ☐ Ache ☐ Sharp ☐ Radiating ☐ Numbness/Tingling

☐ I’m not experiencing pain

Please rate the amount of pain you are generally experiencing (circle one):

*Minor* 1 2 3 4 5 6 7 8 9 10 *Severe*

Have you undergone hyperbaric treatment before? Yes\_\_\_ No\_\_\_

**PLEASE CHECK “C” for Current Conditions and “P” for Conditions you have delt with in the past*:***

**C P C P C P**

\_\_\_ \_\_\_Acid reflux/heart burn \_\_\_ \_\_\_Diabetes \_\_\_ \_\_\_Depression

\_\_\_ \_\_\_Ulcer \_\_\_ \_\_\_Hypoglycemia \_\_\_ \_\_\_Anxiety

\_\_\_ \_\_\_Irritable Bowel \_\_\_ \_\_\_Seizures \_\_\_ \_\_\_Poor memory/confusion

\_\_\_ \_\_\_Diarrhea \_\_\_ \_\_\_Headaches \_\_\_ \_\_\_Arthritis

\_\_\_ \_\_\_Constipation \_\_\_ \_\_\_Migraines \_\_\_ \_\_\_Rheumatoid arthritis

\_\_\_ \_\_\_Sinus problems \_\_\_ \_\_\_Dizziness \_\_\_ \_\_\_Osteopenia or osteoporosis

\_\_\_ \_\_\_Chronic cough \_\_\_ \_\_\_Vertigo \_\_\_ \_\_\_Herniated disc

\_\_\_ \_\_\_Asthma \_\_\_ \_\_\_Balance problems \_\_\_ \_\_\_Muscle cramping

\_\_\_ \_\_\_High blood pressure \_\_\_ \_\_\_Fatigue \_\_\_ \_\_\_Bladder problems

\_\_\_ \_\_\_Stroke \_\_\_ \_\_\_Insomnia \_\_\_ \_\_\_Prostate problems

\_\_\_ \_\_\_Heart Attack \_\_\_ \_\_\_Hypo/Hyper Thyroid \_\_\_ \_\_\_Cancer

\_\_\_ \_\_\_High Cholesterol \_\_\_ \_\_\_Fibromyalgia \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_Clotting disorder \_\_\_ \_\_\_Autoimmune disease

***Would you like to discuss and or seek treatment for any of these additional health concerns? Yes\_\_\_ No\_\_\_***

Do you have a pacemaker? \_\_\_\_Yes \_\_\_\_No

Do you have a history of a stroke? \_\_\_\_\_Yes \_\_\_\_\_No

Do you have a blood clotting disorders? \_\_\_\_\_Yes \_\_\_\_No

FEMALES: Are you pregnant? \_\_\_\_\_Yes \_\_\_\_\_No

Are you on birth control? \_\_\_\_\_ Yes \_\_\_\_\_No If yes, what type? (Injection, pill, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIFESTYLE HABITS**

Exercise: None\_\_\_\_\_ Moderate\_\_\_\_\_ Daily\_\_\_\_\_ What kind of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Activity: Sitting\_\_\_\_\_ Standing\_\_\_\_\_ Light Labor\_\_\_\_\_ Heavy Labor\_\_\_\_\_

Coffee/Caffeine Drinks per Day 0\_\_\_\_\_ 1-3\_\_\_\_\_ 3-5\_\_\_\_\_ 5-7\_\_\_\_\_ More than 7\_\_\_\_\_

Alcohol Drinks per Week 0\_\_\_\_\_ 1-3\_\_\_\_\_ 3-5\_\_\_\_\_ 5-7\_\_\_\_\_ More than 7\_\_\_\_\_

Do you smoke/use tobacco products? \_\_\_\_\_Yes \_\_\_\_\_No Do you vape or use vape products? \_\_\_\_\_Yes \_\_\_\_\_No

Stress Level 0 1 2 3 4 5 6 7 8 9 10

0=Not Stressed 10=Extremely Stressed

Reason for Stress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List any Nutritional Suppliments/Vitamins:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current PERSCRIPTION MEDICATIONS ONLY, including frequency and dosage if known. Please be as specific as possible. IF THERE ARE NO CURRENT MEDICATIONS, CHECK HERE**

Dosage Dosage

**1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_l\_\_\_\_\_\_\_\_\_l 4)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_l\_\_\_\_\_\_\_\_\_l**

**2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_l\_\_\_\_\_\_\_\_\_l 5)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_l\_\_\_\_\_\_\_\_\_l**

**3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_l\_\_\_\_\_\_\_\_\_l 6)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_l\_\_\_\_\_\_\_\_\_l**

**FAMILY HEALTH HISTORY**

**BY USING ONE OF THE FOLLOWING LETTERS, PLEASE INDICATE IF THERE IS A MEMBER IN YOUR FAMILY THAT HAS SUFFERED WITH ONE OF THESE ALIMENTS:**

**F=Father M=Mother B=Brother S=Sister C=Child**

\_\_\_\_\_No Known Conditions \_\_\_\_\_Clotting Disorder \_\_\_\_\_Dementia/Alzheimer’s

\_\_\_\_\_Diabetes/Pre-Diabetes \_\_\_\_\_Heart Disease \_\_\_\_\_High Cholesterol

\_\_\_\_\_High Blood Pressure \_\_\_\_\_Lung Disease \_\_\_\_\_Osteoporosis

\_\_\_\_\_Depression \_\_\_\_\_Anxiety \_\_\_\_\_Stroke/Brain Hemorrhage

\_\_\_\_\_Autism \_\_\_\_\_Attention Deficit Disorder (ADD)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  |  | **Contact**  1415 W Havens St.  Suite 3  Mitchell, SD 57301  Phone: 605.996.1160  Fax: 605.996.6433 |

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| --- |
| **Hyperbaric Oxygen Therapy Screen**  **Patient Information:**  Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Hyperbaric Screening Questions:**  Do you have a history of pneumothorax/collapsed lung? Yes No  Do you have a seizure disorder? Yes No  Do you have claustrophobia or severe anxiety disorder? Yes No  Are you currently pregnant or trying to become pregnant? Yes No  Have you had ear surgery? Yes No  Have you had chest surgery or thoracic surgery? Yes No  Do you have a current upper respiratory infection/cold? Yes No  Do you have chronic ear infections? Yes No  Do you have emphysema? Yes No  Do you have sickle cell anemia? Yes No  Have you ever had radiation therapy? Yes No  Do you have congestive heart failure? Yes No  Do you currently have a migraine? Yes No  Do you have an implanted medical device? (Pacemaker etc.) Yes No |
| **Surgical History:**   |  |  |  | | --- | --- | --- | |  |  |  | |

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| --- |
|  |
| **Please leave the following section for a member of our staff:**   * Discuss the risks and benefits of hyperbaric oxygen   1. Oxygenation, neuroprotection, inflammation, and healing   2. Risks      1. There should be no chest pain      2. Ear discomfort is possible * Discuss the procedure and what to expect   1. Duration, frequency of treatment   2. How to clear the ears   3. Getting to and coming down from pressure * Discuss any medical conditions that may affect their response to the therapy * Discuss the patient's anxiety and potential coping strategies for managing their anxiety during the therapy. * Ensure the patient has a comfortable outfit and that they have emptied their bladder before entering the chamber. * Inform the patient about any potential sensations or noises they may experience during the therapy session, and explain how to communicate with the staff inside the chamber if they become uncomfortable. |
| **Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |