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www.PittsburghAlternativeHealth.com
"Seeking Truth In and Through Natural Medicine" John 18:37

Mild Hyperbaric Therapy - Intake Questionnaire

Continue only if:

Not currently prescribed or taking medications of: Bleomycin, Disulfiram, Mafernide Acetate
Do not have or suspect having: Hereditary Sperocytosis, Sickle Cell Anemia, COPD

Name: ______________________________ Date: ____________________

Street Address: ______________________________ Date of Birth: ______________ Age: _____

City: ______________________________ State: ____________ Zip Code: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Email Address: ______________________________ Gender: Male ______ Female ______

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Minor, Parent or Legal Guardian Name: ______________________________

Spouse's Name: ______________________________

Spouse Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Person to Contact in Case of Emergency: ______________________ Phone: ______________

What is Your Primary Reason for Using the Mild Hyperbaric Chamber?

____
____
____
____

Do you have a valid prescription from your doctor for Oxygen Therapy? ☐ Yes ☐ No

How did you hear about our Clinic? ______________________________

Physician Information:

Are you Currently Under a Doctor's Care? ☐ Yes ☐ No

Physician's Name: ______________________________ Phone: ____________________

Address: ______________________________

City: ______________________________ State: ____________ Zip Code: ______________

Phone: ______________________________ Fax: ______________________________

Medical History

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Do you exercise on a regular basis?	☐	☐
If so, how often? ____________________		
3. Do you use tobacco?	☐	☐
4. Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years?	☐	☐
If yes, please explain.		

____
____
____
____
____

	Yes	No
5. Do you use alcohol?	☐	☐
If so, how often? ____________________		
6. Are you pregnant or think you may be pregnant??	☐	☐
If so, how many weeks? ______________		
If NO, what was the date of your last menstrual period? ____________________		
7. Are you taking any medications?	☐	☐
If yes, what medications are you taking?		

____
____
____
____
____

8. List any medications you are allergic to: ____

____

9. Do you have or have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Acute Respiratory Illness	☐	☐	Frequent Ear Infections	☐	☐	Mitral Valve Prolapse	☐	☐
AIDS or HIV Infection	☐	☐	Frequently Tired	☐	☐	Neurological Disease	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation Therapy	☐	☐
Angina	☐	☐	Hay Fever/Allergies	☐	☐	If YES, When? __________		
Anxiety	☐	☐	Hepatitis/Jaundice	☐	☐	Recent Weight Loss	☐	☐
Arthritis	☐	☐	Heart Attack	☐	☐	Respiratory Problems	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Rheumatic Fever	☐	☐
Back Pain	☐	☐	Heart Murmur	☐	☐	Ringing in the Ears	☐	☐
Cancer	☐	☐	Heart Problems	☐	☐	Rosacea	☐	☐
Chemical Sensitivity	☐	☐	Herpes	☐	☐	Seizure Disorders	☐	☐
Chest Pains	☐	☐	High Blood Pressure	☐	☐	Stomach Problems/Ulcers	☐	☐
Chronic Bronchitis	☐	☐	Infections, Frequent	☐	☐	Stroke	☐	☐
Chronic Fatigue (CFS)	☐	☐	Kidney Disease	☐	☐	Swollen Ankles	☐	☐
Claustrophobia	☐	☐	Leukemia	☐	☐	Thyroid Problems	☐	☐
Diabetes	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Low Blood Pressure	☐	☐	Other:	☐	☐
Fainting / Seizures	☐	☐	Lung Disease	☐	☐	____________________	☐	☐
Fever Related Seizures	☐	☐	Lung Infection, Frequent	☐	☐	____________________	☐	☐
Fibromyalgia	☐	☐	Malignant Disease	☐	☐	____________________	☐	☐

	Yes	No
10. Have you ever had any ear problems?	☐	☐
11. Do you have any problems with your ears when you fly?	☐	☐
12. Do you have any problems going up and down in an elevator?	☐	☐
13. Do you have any back problems?	☐	☐

Patient Comments:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the release of any medical information from my chart to any physician or physicians who may be involved in my medical treatment. <u>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.</u> I agree to be responsible for payment of all services rendered on my or my dependents behalf.

____

Signature of patient (parent or guardian)