BAROMEDICAL

Medical Hyperbaric Oxygen Clinic
Wound Care Centre

CLIENT INTAKE FORM FOR HYPERBARIC ASSESSMENT

Today's date: dd / mmm / yyyy

CLIENT INFORMATION

❑ Mr. ❑ Miss ❑ Dr. ❑ Mrs. ❑ Ms. ❑ _____	❑ male ❑ female ❑ _____	❑ single ❑ married / common law ❑ divorced ❑ separated ❑ widowed	Date of birth: dd / mmm / yyyy
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 ⇨

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CANADA

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Web: www.BaroMedical.ca

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 or suspect pregnancy?	Yes	No
	❑	❑

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
Acute Respiratory Illness	❑	❑
AIDS or HIV infection	❑	❑
Anemia	❑	❑
Angina	❑	❑
Anxiety	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Back pain	❑	❑
Cancer	❑	❑
Chemical sensitivity	❑	❑
Chest pains	❑	❑
Chronic bronchitis	❑	❑
Chronic fatigue syndrome (CFS)	❑	❑
Claustrophobia	❑	❑
Diabetes	❑	❑
Emphysema	❑	❑
Fainting / seizures	❑	❑
Fibromyalgia	❑	❑

	Yes	No
Frequent ear infections	❑	❑
Frequently tired	❑	❑
Glaucoma	❑	❑
Hay fever / allergies	❑	❑
Hepatitis / jaundice	❑	❑
Heart attack	❑	❑
Heart disease	❑	❑
Heart problems	❑	❑
Herpes	❑	❑
High blood pressure	❑	❑
Infections, frequent	❑	❑
Kidney disease	❑	❑
Leukemia	❑	❑
Liver disease	❑	❑
Low blood pressure	❑	❑
Lung disease	❑	❑
Lung infection, frequent	❑	❑
Malignant disease	❑	❑

	Yes	No
Mitral valve prolapse	❑	❑
Neurological disease	❑	❑
Radiation therapy	❑	❑
If so, when: _____		
Recent weight loss	❑	❑
Respiratory problems	❑	❑
Rheumatic fever	❑	❑
Ringing in the ears	❑	❑
Rosacea	❑	❑
Seizure disorders	❑	❑
Stomach problems / ulcer	❑	❑
Stroke	❑	❑
Swollen ankles	❑	❑
Thyroid problems	❑	❑
Tuberculosis	❑	❑
Chest X-ray in the last 6 months	❑	❑
COVID positive test	❑	❑

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: _____

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