HealthUP

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 ⇨

MEDICAL HISTORY

HealthUP Oxygenation Clinics
7850 Sixth Street, Burnaby, V3N 3N3
British Columbia
CANADA

Phone: +1 604.777.7055
Fax: +1 .604.777.7044
Email: frontdesk@HealthUP.ca
Web: www.HealthUP.ca

Do you exercise on a regular basis?	Do you use:	If applicable, are you pregnant
If yes, how often:_____ ❑	❑ Tobacco / vaping ❑ Recreational drugs ❑ Alcohol	or suspect pregnancy? ❑

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?

❑ 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 so, when: _____
❑ Anxiety	❑ Hepatitis / jaundice	❑ Recent weight loss
❑ Arthritis	❑ Heart attack	❑ Respiratory problems
❑ Asthma	❑ Heart disease	❑ Rheumatic fever
❑ Back pain	❑ Heart problems	❑ Ringing in the ears
❑ Cancer	❑ Herpes	❑ Rosacea
❑ Chemical sensitivity	❑ High blood pressure	❑ Seizure disorders
❑ Chest pains	❑ Infections, frequent	❑ Stomach problems / ulcer
❑ Chronic bronchitis	❑ Kidney disease	❑ Stroke
❑ Chronic fatigue syndrome (CFS)	❑ Leukemia	❑ Swollen ankles
❑ Claustrophobia	❑ Liver disease	❑ Thyroid problems
❑ Diabetes	❑ Low blood pressure	❑ Tuberculosis
❑ Emphysema	❑ Lung disease	
❑ Fainting / seizures	❑ Lung infection, frequent	❑ Chest X-ray in the last 6 months
❑ Fibromyalgia	❑ Malignant disease	❑ COVID positive test

Do you have any ear problems?:	Notes / comments:
❑ Problems with your ears when flying ❑ Problems with your ears riding an elevator ❑ Problems with your ears going up or down mountains	

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 to me or on my dependent's behalf.

Signature: _____ **Date**: _____

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