

Thank you for selecting our hyperbaric team! We will strive to provide you with the best possible service. To help us meet all of your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

Hyperbaric Therapy Registration and History

Continue only if:

You are not currently prescribed or taking medications: *Bleomycin, Disulfiram, Mafernade and, Acetate*
Do not have or suspect having: *Hereditary Spherocytosis, Sickle Cell Anemia, and COPD*

Patient Information Date: / /

Name: _____
First Middle Last

Address: _____

City State Zip

Email: _____
 Sign up for Team DC newsletter

Pref. Phone:
 Home: - -
 Work: - - Ext. _____
 Cell: - -
 Sign up for text reminders
Cell Carrier: _____

How did you hear about us? _____
Who referred you to our office? _____

Date of Birth: / / Age: _____

S.S. #: - - Sex: M F

Marital Status: Married Divorced Live w/ partner
 Minor Separated Widowed

Spouse Name: _____

Parents/Guardians: _____
(Only if patient is a minor)

Emergency Contact: _____
Relationship: _____
Phone: - -

What is your primary reason for coming to DC Hyperbaric Therapy Center, LLC? _____

Physician Information Date: / /

Are you currently under a doctor's care for this condition? Y N If Yes, who? _____

Address: _____

City State Zip

Phone: - -
Fax: - -

Health History *Please answer the rest of these questions as completely as possible.*

ALLERGY INFORMATION Are you allergic to anything? Y N *If yes, please continue filling out the allergy portion.*
What are you allergic to? _____

MEDICAL INFORMATIONDo/Have you have/had a major illness? Y N *If yes, please check all that apply.*

Previously Presently	<input type="checkbox"/> <input type="checkbox"/>	Acute Respiratory Illness	Previously Presently	<input type="checkbox"/> <input type="checkbox"/>	Emphysema	Previously Presently	<input type="checkbox"/> <input type="checkbox"/>	Kidney Disease	Previously Presently	<input type="checkbox"/> <input type="checkbox"/>	Respiratory Problems
	<input type="checkbox"/> <input type="checkbox"/>	AIDS/HIV		<input type="checkbox"/> <input type="checkbox"/>	Fainting / Seizures		<input type="checkbox"/> <input type="checkbox"/>	Leukemia		<input type="checkbox"/> <input type="checkbox"/>	Rheumatic Fever
	<input type="checkbox"/> <input type="checkbox"/>	Anemia		<input type="checkbox"/> <input type="checkbox"/>	Fever Related Seizures		<input type="checkbox"/> <input type="checkbox"/>	Liver Disease		<input type="checkbox"/> <input type="checkbox"/>	Rheumatoid Arthritis
	<input type="checkbox"/> <input type="checkbox"/>	Angina		<input type="checkbox"/> <input type="checkbox"/>	Fibromyalgia		<input type="checkbox"/> <input type="checkbox"/>	Low Blood Pressure		<input type="checkbox"/> <input type="checkbox"/>	Stomach Ulcers
	<input type="checkbox"/> <input type="checkbox"/>	Anxiety		<input type="checkbox"/> <input type="checkbox"/>	Frequent Ear Infections		<input type="checkbox"/> <input type="checkbox"/>	Lung Disease		<input type="checkbox"/> <input type="checkbox"/>	Stroke
	<input type="checkbox"/> <input type="checkbox"/>	Arthritis		<input type="checkbox"/> <input type="checkbox"/>	Frequently Tired		<input type="checkbox"/> <input type="checkbox"/>	Frequent Lung Infection		<input type="checkbox"/> <input type="checkbox"/>	Swollen Ankles
	<input type="checkbox"/> <input type="checkbox"/>	Asthma		<input type="checkbox"/> <input type="checkbox"/>	Glaucoma		<input type="checkbox"/> <input type="checkbox"/>	Malignant Disease		<input type="checkbox"/> <input type="checkbox"/>	Thyroid Problems
	<input type="checkbox"/> <input type="checkbox"/>	Back Pain		<input type="checkbox"/> <input type="checkbox"/>	Hay Fever/Allergies		<input type="checkbox"/> <input type="checkbox"/>	Multiple Sclerosis		<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis
	<input type="checkbox"/> <input type="checkbox"/>	Cancer		<input type="checkbox"/> <input type="checkbox"/>	Heart Attack		<input type="checkbox"/> <input type="checkbox"/>	Mitral Valve Prolapse		<input type="checkbox"/> <input type="checkbox"/>	Other/Comments: _____
	<input type="checkbox"/> <input type="checkbox"/>	Chemical Sensitivity		<input type="checkbox"/> <input type="checkbox"/>	Heart Disease		<input type="checkbox"/> <input type="checkbox"/>	Neurological Disease			_____
	<input type="checkbox"/> <input type="checkbox"/>	Chest Pains		<input type="checkbox"/> <input type="checkbox"/>	Heart Murmur		<input type="checkbox"/> <input type="checkbox"/>	Radiation Therapy	If yes, when?		_____
	<input type="checkbox"/> <input type="checkbox"/>	Chronic Bronchitis		<input type="checkbox"/> <input type="checkbox"/>	Heart Problems		<input type="checkbox"/> <input type="checkbox"/>	Recent Weight Loss			_____
	<input type="checkbox"/> <input type="checkbox"/>	Chronic Fatigue (CFS)		<input type="checkbox"/> <input type="checkbox"/>	Hepatitis/Jaundice		<input type="checkbox"/> <input type="checkbox"/>	Osteoporosis			_____
	<input type="checkbox"/> <input type="checkbox"/>	Claustrophobia		<input type="checkbox"/> <input type="checkbox"/>	Herpes		<input type="checkbox"/> <input type="checkbox"/>	Parkinson's Disease			_____
	<input type="checkbox"/> <input type="checkbox"/>	Diabetes		<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure						_____
				<input type="checkbox"/> <input type="checkbox"/>	Infections, Frequent						_____

Please list the dates of all checked: _____

Are you pregnant? Y N If so, how many weeks? _____

Are you currently taking any medications? Y N Please list: _____

Have you hospitalized in the last 5 years? Y N Please list: _____

Have you ever had any ear problems? Y N Do you have any problems with your ears when you fly? Y N

Do you have back problems? Y N Do you have any problems with your ears in an elevator? Y N

SOCIAL HISTORY

Smoking	<input type="checkbox"/> Never	<input type="checkbox"/> Former	<input type="checkbox"/> Current	How many years?	_____	Comments:
Alcohol	<input type="checkbox"/> Never	<input type="checkbox"/> Former	<input type="checkbox"/> Current	Drinks p/week	_____	_____
Exercise	<input type="checkbox"/> Never	<input type="checkbox"/> Everyday	<input type="checkbox"/> Weekly		_____	_____
<i>all that apply</i>	<input type="checkbox"/> Walks	<input type="checkbox"/> Runs	<input type="checkbox"/> Swims	<input type="checkbox"/> Other	_____	_____

AUTHORIZATION

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. 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 of Patient (or parent/guardian)_____
Date

The technology, known as mild Hyperbaric Therapy (mHBT), has been reported to have beneficial effects for a wide range of conditions, without negative side effects. Nevertheless, as with many treatments, there are areas of concern which you should be aware. It is important that you take a few minutes to read the following information.

OTIC BAROTRAUMA: Is a condition of injury to the eardrum, and is extremely unlikely to occur in the mild hyperbaric chamber. However, severe ear discomfort can be caused if you cannot equalize the pressure in your ears. As the chamber is pressurized and depressurized you must be able to equalize the pressure in your ears to acclimate to the pressure changes. You will most likely experience "popping" in your ears. This is normal. You can assist the equalization process by yawning, chewing, swallowing, working your jaw side to side and up and down, turning the head side to side and ear to shoulder. Sitting upright in the chamber during pressurization and depressurization will generally also make the equalization process more comfortable. In general, doing whatever assists you being comfortable when taking off and landing in a plane may be most effective for you. Continue to do this as needed for the duration of pressurization and depressurization. When the chamber reaches full pressure and again when the chamber is completely deflated there should be no additional pressure in the ears. **IF YOU ARE UNABLE TO EQUALIZE EAR PRESSURE AND EXPERIENCE PAIN IN ONE OR BOTH EARS, IT IS CRITICAL THAT YOU COMMUNICATE ANY DISCOMFORT IMMEDIATELY TO THE STAFF.** This will give us the opportunity to make adjustments in the pressurization or depressurization process to eliminate discomfort. If you are unable to equalize the pressure in your ears the visit will be immediately terminated. If this happens or if pain persists beyond the visit, we recommend that you consult your physician to evaluate and alleviate the situation before attempting another visit.

EAR, SINUS AND/OR THROAT CONGESTION, HEAD COLDS, VIRUS OR PRIOR TRAUMA TO THE EARS: You may consider rescheduling your visit in the chamber if you are suffering from any of these conditions. Discomfort from these conditions is less frequent but may occur. **IF YOU ARE UNABLE TO EQUALIZE EAR PRESSURE AND EXPERIENCE PAIN IN ONE OR BOTH EARS, IT IS CRITICAL THAT YOU COMMUNICATE ANY DISCOMFORT IMMEDIATELY TO THE STAFF** so we can assist you or terminate your visit. We recommend you consult your physician in order to alleviate the underlying condition before attempting another visit.

PULMONARY HYPEREXPANSION: This condition is very rare under mild hyperbaric treatments. However, to be overly cautious, **HOLDING YOUR BREATH DURING DECOMPRESSION MUST BE AVOIDED** as it could lead to expansion of the air in your lungs and damage to the lung tissues. In the highly unlikely event of an unexpected rapid decompression, it is critical that you exhale immediately.

MEDICATIONS: mild Hyperbaric Therapy may enhance the effectiveness or increase the metabolism (decrease the effectiveness) of any medication you are taking. **IT IS RECOMMENDED THAT YOU HAVE THE DOSAGE AND FREQUENCY OF ALL MEDICATIONS MONITORED AND ADJUSTED REGULARLY BY YOUR PHYSICIAN.**

PREGNANCY: MILD HYPERBARIC THERAPY IS NOT ALLOWED DURING THE FIRST TRIMESTER. After this time it may be beneficial to both mother and child.

I have been informed and advised by the staff that there will be **NO FOOD, DRINK, GUM, CANDY, OR ANY OTHER EDIBLES** in the chamber.

SEIZURES: mild Hyperbaric Therapy is not associated with causing or inducing seizures. To be on the cautious side we have established a seizure protocol that involved reaching full pressure(4.2psi) and spending full treatment time (standard 1 hour) in the chamber over a series of staged visits. **IF ANYONE IN GETTING IN THE CHAMBER IS SEIZURE PRONE, THE STAFF MUST BE MADE AWARE PRIOR TO THE FIRST VISIT.** If a seizure is experienced in our clinic, unless otherwise instructed (and a waiver is signed), our procedure is to call 911, remove the patient from the chamber and make the individual as comfortable as possible.

DETOXIFYING OR CELL DIE-OFF: mild Hyperbaric Therapy may assist the body to naturally detoxify and balance digestive flora. **AN INDIVIDUAL MAY EXPERIENCE SOME DISCOMFORT FROM THIS PROCESS IN AS LITTLE AS 1 TO 36 HOURS AFTER TREATMENT.** Symptoms may include; flu like symptoms, loss of appetite, stomach ache, constipation, diarrhea, headache, behavioral issues etc. Although unpleasant, this is a natural process and continuing treatments may be of benefit to more rapidly accomplish a positive result. However **IF SYMPTOMS PERSIST, WE RECOMMEND CONSULTING YOUR PHYSICIAN TO EVALUATE AND ALLEVIATE THE SITUATION BEFORE ATTEMPTING ANOTHER VISIT.**

INITIALS _____

PNEUMOTHORAX: mild Hyperbaric Therapy is contraindicated for an existing pneumothorax (collapsed lung). **IF YOU HAVE A PNEUMOTHORAX OR SUSPECT THAT A PNEUMOTHORAX IS AN ISSUE, YOU WILL NOT BE ALLOWED IN THE CHAMBER UNTIL YOU/WE RECEIVE A DOCTOR'S CLEARANCE.** If you have experienced a pneumothorax in the past and have already been "cleared from your doctor" to resume normal activity, once you have provided a written confirmation you should be able to proceed with mild Hyperbaric Therapy.

COMPRESSIVE BRAIN LESIONS – SUBDURAL HEMATOMA, INTERCRANIAL HEMATOMA: mild Hyperbaric Therapy is contraindicated for existing compressive brain lesions (subdural hematoma, intercranial hematoma). **IF YOU HAVE COMPRESSIVE BRAIN LESIONS OR SUSPECT THAT COMPRESSIVE BRAIN LESIONS ARE AN ISSUE, YOU WILL NOT BE ALLOWED IN THE CHAMBER UNTIL YOU/WE RECEIVE A DOCTOR'S CLEARANCE.** If you have experienced compressive brain lesions in the past and have already been "cleared from your doctor" to resume normal activity, once you have provided a written confirmation you should be able to proceed with mild Hyperbaric Therapy.

DIABETES / INSULIN DEPENDENT: Insulin dependency may result in a drop in blood sugar while in the chamber. **IT IS CRITICAL THAT YOU IMMEDIATELY COMMUNICATE TO THE STAFF IF YOU EXPERIENCE OR ANTICIPATE AN EPISODE. YOUR TREATMENT WILL BE TERMINATED.** You are required to; A) take a blood sugar reading prior to your treatment (if below 150, you must have a snack prior to treatment) and again after your treatment (if below 150, you must have a snack prior to leaving). B) Take a protein bar and a juice box (or whatever you use if faced with a "drop" in the normal management of your condition) into the chamber with you.

SENSITIVITY TO CHEMICALS (MCS) / ODORS / ALLERGY: Avoid wearing heavy colognes as the smells may linger in the chamber and have an adverse effect on another patient. **IF YOU EXPERIENCE ADVERSE SENSITIVITY OR HAVE ALLERGIES THAT MAY BECOME AGGRAVATED WHILE IN THE CHAMBER, LET THE STAFF KNOW PRIOR TO YOUR VISIT OR AS SOON AS POSSIBLE WHEN IN THE CHAMBER SO MEASURES CAN BE TAKEN TO ASSURE YOUR COMFORT OR IF YOUR VISIT NEEDS TO BE TERMINATED.** We recommend that you wearing a charcoal mask or filter if it is known to assist your condition. If these sensitivities persist and you cannot exist comfortably in the chamber, you will need to consult your physician in order to alleviate the underlying condition before attempting another visit.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION.

Signature of Patient (or parent/guardian)

 / /

Date