FORT WAYNE INTEGRATIVE MEDICINE

FORT WAYNE PRIMARY CARE

Attention Patients

Please print and complete this form and bring it to your next Office Visit. If this is not possible, please arrive 30 minutes prior to your appointment to complete Patient Intake Forms.

Hyperbaric Oxygen Patient Intake Form

TODAY'S DATE	

1. _____ (Patient initials) Cancelations or rescheduled appointments require a 72-hour (3 business days) advance notice. If this timeframe is not met, there is a $50 fee, this fee also applies to missed appointments. A refund for Hyperbaric Oxygen sessions is permitted up to 10 business days after purchase. After 10 days an Office Credit will be issued. Some exceptions may be allowed but will require an Office Manager approval.

PERSONAL INFORMATION

PATIENT'S NAME						
DATE OF BIRTH		AGE		SEX	F	M
PARENT'S NAME *(if applicable)*						
STREET ADDRESS						
CITY		STATE		ZIP		
HOME PHONE		CELL PHONE		BUSINESS PHONE		
E-MAIL ADDRESS						
MARITAL STATUS	☐ Minor	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
EMPLOYMENT	☐ Minor	☐ Full-time	☐ Part-time	☐ Unemployed	☐ Disabled	☐ Retired

EMERGENCY CONTACT

NAME			
DAYTIME PHONE		RELATIONSHIP TO PATIENT	
STREET ADDRESS			
CITY		STATE	ZIP

REFERRAL

HOW DID YOU HEAR ABOUT OUR FACILITY?	Friend/Family	Online	Other_____
WHO CAN WE THANK FOR YOUR REFERRAL?			
E-MAIL ADDRESS		PHONE	

CURRENT HEALTH CONCERNS

CONCERNS (PLEASE LIST IN ORDER OF PRIORITY)	PREVIOUS TREATMENT
1.	
2.	
3.	
4.	
5.	

PHYSICIAN

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE?	☐ Yes	☐ No			
DID THEY RECOMMEND HYPERBARIC OXYGEN THERAPY?	☐ Yes	☐ No			
DO YOU HAVE A PRESCRIPTION FOR HYPERBARIC OXYGEN THERAPY?	☐ Yes	☐ No			
PHYSICIAN'S NAME				SPECIALTY	
STREET ADDRESS					
CITY		STATE		ZIP	
PHONE		FAX			

SOCIAL HISTORY

TOBACCO USE	☐ Never	☐ Previously, but Quit	☐ Currently	> IF YES, # PACKS/DAY	
CAFFEINE USE	☐ Never	☐ Yes	> IF YES, LIST FREQUENCY & SOURCE OF CAFFEINE		
ALCOHOL USE	☐ Never	☐ Rarely	☐ Moderately	☐ Daily	
DRUG USE	☐ Never	☐ Yes	> IF YES, LIST FREQUENCY & TYPE OF DRUG USE		

1. CURRENT MEDICATIONS *(List all medicines you are currently taking including prescription and over the counter)*

MEDICATION	DOSAGE	FREQUENCY

1b. CURRENT MEDICATIONS (CONTINUED)

2. ALLERGIES *(please list all known allergies)*

3. DIABETES

DO YOU HAVE DIABETES?	☐ Yes	☐ No	
> IF YES, DO YOU TAKE:	☐ insulin	☐ oral agents	☐ diet controlled
> IF YES, HOW OFTEN DO YOU TEST YOUR BLOOD SUGAR?	_____ time(s)/day		

4. PULMONARY LUNG DIAGNOSIS

HAVE YOU EVER BEEN DIAGNOSED WITH ANY LUNG / PULMONARY CONDITION, OR PULMONARY FIBROSIS?	☐ No	☐ Yes
> IF YES, WHAT IS THE CONDITION?		

5. SEIZURE OR CONVULSION ACTIVITY

ARE YOU EXPERIENCING SEIZURES OR CONVULSIONS OR HAVE YOU BEEN TOLD THAT YOU ARE AT RISK FOR SEIZURES?	☐ No	☐ Yes
> IF YES, WHAT IS THE CONDITION(S)?		

6. PREGNANCY STATUS

ARE YOU PREGNANT OR THINK YOU COULD BE?	☐ No	☐ Yes

7. EAR HISTORY

a) HAVE YOU EVER HAD EAR PROBLEMS?	☐ No	☐ Yes
b) DO YOU HAVE ANY PROBLEMS WITH YOUR EARS WHEN YOU FLY?	☐ No	☐ Yes
c) DO YOU HAVE ANY PROBLEMS GOING UP AND DOWN IN AN ELEVATOR?	☐ No	☐ Yes

d) DO YOU OR HAVE YOU EVER DONE SCUBA DIVING?	☐ No	☐ Yes
e) DO YOU KNOW HOW TO EQUALIZE PRESSURE IN YOUR EARS?	☐ No	☐ Yes

8. MEDICAL IMPLANTS

DO YOU HAVE ANY IMPLANTED MEDICAL DEVICES?	☐ No	☐ Yes
> IF YES, PLEASE DESCRIBE THE DEVICE, MANUFACTURER AND DATE IMPLANTED.		

9. NUTRITION PROFILE

a) DO YOU HAVE DIFFICULTY CHEWING OR SWALLOWING?	☐ No	☐ Yes
b) DO YOU NEED ASSISTANCE FOR EATING?	☐ No	☐ Yes
c) HAVE YOU HAD A LARGE WEIGHT LOSS OR WEIGHT GAIN?	☐ No	☐ Yes
> IF YES:	_____ lbs.	_____ months
> IF YES, REASON (IF KNOWN):		
d) DO YOU HAVE A SPECIAL DIET?	☐ No	☐ Yes
> IF YES, PLEASE EXPLAIN:		
e) DO YOU HAVE ANY FOOD ALLERGIES OR SENSITIVITIES?	☐ No	☐ Yes
> IF YES, PLEASE EXPLAIN:		
f) ARE YOU INVOLVED IN A WEIGHT LOSS PROGRAM?	☐ No	☐ Yes
> IF YES, PLEASE EXPLAIN:		
g) HOW IS YOUR APPETITE?	☐ Good ☐ Fair ☐ Poor	
h) HOW MUCH WATER DO YOU DRINK EACH DAY?	_____glasses	
i) DO YOU EXERCISE REGULARLY?	☐ No	☐ Yes
j) DO YOU TAKE VITAMINS OR SUPPLEMENTS	☐ No	☐ Yes

> IF YES, LIST ALL VITAMINS AND/OR SUPPLEMENTS TAKEN.

SUPPLEMENT	DOSAGE	FREQUENCY