NJ HBOT CENTER

Patient Intake Form

Today's Date: _____

Patient's Name: _____ DOB: _____ Age____

Sex: ___M___ F

Parent's Name (if applicable): _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Business: _____

E-mail Address:

_____

Check: ___ Minor ___ Single ___ Married ___ Divorced ___Widowed ___ Separated

Employment Status: __Full--time __Part--time __ Unemployed __Disabled ___Retired ___ Minor

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Daytime Phone: _____

Referring Physician: _____ Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

How did you hear about Core Therapies? _____

NJ HBOT Center
17 Hanover Road, Bldg. 300
Florham Park, NJ 07932
973.620.8100

Current Health Concerns (in order of priority):

1._____

2. _____

3._____

4._____

5._____

Physician

Are you currently under a doctor's care? _____ Yes _____ No

Physician's Name: _____ Specialty _____

Street Address: _____City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

Do you have a prescription for hyperbaric oxygen therapy? _____ Yes _____ No

Have you had any previous hyperbaric treatment? _____ Yes _____ No

If yes, where? _____

Social History

Tobacco Use: ____ Never ____ Previously, but quit ____ Current packs/day_____

Caffeine Use: ____ Never _____ Frequency _____Source of caffeine _____

Alcohol Use: ____ Never ____ Rarely ____ Moderate ____ Daily

Drug Use: ____ Never _____ Frequency _____ Type

Patient's Medical History

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

Medication	Dosage	Frequency

2. ALLERGIES (Please list all known allergies)

_____

_____

3. DIABETES

a. Do you have diabetes? Yes / No (Please circle one)

b. If yes, do you take: (Please circle all that apply) Insulin Oral agents Diet Controlled

c. How often do you test your blood sugar? _____ times/day

4. PULMONARY/LUNG DIAGNOSIS

Have you ever been diagnosed with any lung/pulmonary condition, or pulmonary fibrosis?

Yes / No (Please circle one)

If yes, what is the condition/s:

_____

5. SEIZURE OR CONVULSION ACTIVITY

Are you experiencing seizures or convulsions or have you been told that you are at risk for seizures? Yes / No (Please circle one)

If yes, please describe

_____

6. PREGNANCY STATUS

Are you pregnant or think you may be? Yes / No (Please circle one)

7. EAR HISTORY (Please circle yes or no)

Have you ever had ear problems? Yes No

Do you have any problems with your ears when you fly? Yes No

Do you have any problems going up and down in an elevator? Yes No

Do you or have you ever done scuba diving? Yes No

8. NUTRITION PROFILE (Please circle yes or no)

Difficulty chewing or swallowing? Yes No

Assistance needed for eating? Yes No

Have you had a large weight loss or weight gain? Yes No

If yes, ____ lbs in ____ months

Reason if known: _____

Special Diet? Yes No If yes, Please explain:

_____

Food allergies? Yes No If yes, Please explain:

_____

Are you involved in a weight loss program: Yes No If yes, Please explain:

_____

Appetite: Good Fair Poor

How much water do you drink each day? _____ glasses

Do you take vitamins or other supplements? Yes No

Supplement	Dosage	Frequency

Do you exercise regularly? Yes No