Dr. Carolyn Flanary

Client Intake Form

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TODAY'S DATE	

PERSONAL INFORMATION

Clear Form

PATIENT'S NAME					
DATE OF BIRTH		AGE	SEX ☐ F ☐ M	HEIGHT	WEIGHT
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

1 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
d) DO YOU KNOW HOW TO EQUALIZE PRESSURE IN YOUR EARS?	☐ No	☐ Yes

8. MEDICAL IMPLANTS

DO YOU HAVE ANY IMPLANTED MEDICAL OR COSMETIC 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