

Patient Intake Form



900 42nd Street
Des Moines, IA 50312
(515) 421-4002
Iowahbot.com

TODAY'S DATE

PERSONAL INFORMATION

PATIENT'S NAME					
DATE OF BIRTH	AGE	SEX <input type="checkbox"/> F <input type="checkbox"/> M			
PARENT'S NAME <i>(if applicable)</i>					
STREET ADDRESS					
CITY	STATE	ZIP			
HOME PHONE	CELL PHONE	BUSINESS PHONE			
E-MAIL ADDRESS					
MARITAL STATUS	<input type="checkbox"/> Minor	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
EMPLOYMENT	<input type="checkbox"/> Minor	<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Disabled <input type="checkbox"/> Retired

EMERGENCY CONTACT

NAME			
DAYTIME PHONE	RELATIONSHIP TO PATIENT		
STREET ADDRESS			
CITY	STATE	ZIP	

REFERRAL

HOW DID YOU HEAR ABOUT OUR FACILITY?	<input type="checkbox"/> Friend/Family	<input type="checkbox"/> Online	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DID THEY RECOMMEND HYPERBARIC OXYGEN THERAPY?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DO YOU HAVE A PRESCRIPTION FOR HYPERBARIC OXYGEN THERAPY?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PHYSICIAN'S NAME		SPECIALTY
STREET ADDRESS		
CITY	STATE	ZIP
PHONE	FAX	

SOCIAL HISTORY

TOBACCO USE	<input type="checkbox"/> Never	<input type="checkbox"/> Previously, but Quit	<input type="checkbox"/> Currently	> IF YES, # PACKS/DAY
CAFFEINE USE	<input type="checkbox"/> Never	<input type="checkbox"/> Yes	> IF YES, LIST FREQUENCY & SOURCE OF CAFFEINE	
ALCOHOL USE	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Moderately	<input type="checkbox"/> Daily
DRUG USE	<input type="checkbox"/> Never	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
> IF YES, DO YOU TAKE:	<input type="checkbox"/> insulin	<input type="checkbox"/> oral agents <input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
> IF YES, WHAT IS THE CONDITION(S)?		

6. PREGNANCY STATUS

ARE YOU PREGNANT OR THINK YOU COULD BE?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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7. EAR HISTORY

a) HAVE YOU EVER HAD EAR PROBLEMS?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b) DO YOU HAVE ANY PROBLEMS WITH YOUR EARS WHEN YOU FLY?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c) DO YOU HAVE ANY PROBLEMS GOING UP AND DOWN IN AN ELEVATOR?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d) DO YOU OR HAVE YOU EVER DONE SCUBA DIVING?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d) DO YOU KNOW HOW TO EQUALIZE PRESSURE IN YOUR EARS?	<input type="checkbox"/> No	<input type="checkbox"/> 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