Nardella
Creating Healthier Lives

Hyperbaric Oxygen Therapy Intake Form

Personal Information

Date: _____

Name: _____ Age: _____

Birth Date: ____dd/mm/yyyy_____ Sex: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Telephone: (Home) _____ (Cell) _____

Email: _____

Occupation: _____

Do you have extended health insurance? ☐Yes ☐No

If yes, please list provider: _____

Family Physician: _____

Phone Number: _____ Fax Number: _____

In Case of emergency contact: _____

Address: _____ Phone Number: _____

Relationship: _____

How did you hear about our clinic? _____

Have you seen a Naturopathic Doctor before? ☐Yes ☐No

If yes, for what reason(s)? _____

I would like to be on the clinic's general mailing list to receive clinic information, such as subscriber specials and the clinic newsletter. Please circle YES/NO.

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Current Health History

What is your major health concern? _____
_____
How long have you had this condition? _____
What activities aggravate your condition? _____

Please list any other health concerns you have:
1. _____ 2. _____ 3. _____

Please list all known allergies (medications, food, pollen, etc.):
_____
_____
_____

Have you ever had any mental or emotional disorders? _____ If yes, when? _____

Do you smoke? Yes ___ No____

Height _____ Weight _____

What other therapies are you currently using? (Chiropractic, Physiotherapy, Acupuncture etc)
_____
_____

Medication and Supplement History

Please list all supplements, herbs and medications you are currently taking:

Medication/Supplement	Dosage	Since	Reason

History of antibiotic use: (last two years)
When: _____
How long: _____
For what condition(s):
_____
_____

Health History

Please indicate the reason for treatment: _____

Please indicate if you have or have had any of the following:

Medications:	**General:**	
__ *Bleomycin*	__ Chronic Sinusitis	__ Congestive heart failure
__ *Cis-Platinum*	__ Seizure Disorder	__ Congenital spherocytosis
__ *Disulfiram*	__ Emphysema with CO2 retention	__ History of optic neuritis
__ *Doxorubicin*	__ High Fevers	__ History of confinement anxiety
__Mefenide Acetate	__ *History of spontaneous pneumothorax*	__ History of blood sugar regulation problems
Equipment:	__ History of thoracic surgery	__ Diabetes
__ Pacemaker	__ History of surgery for otosclerosis (ear surgery)	__ Upper Respiratory Infections
__ Portacath	__ Viral Infections	__ Pulmonary lesions on routine x-ray or CT scan
__ Other:_____	__ Sickle cell anemia	__ Cataracts __ Retinal tears

Please indicate if you've had any hospitalizations, surgeries, or serious injuries:

Operation	When	Complications?

Family Health History

Please indicate any relevant health conditions of your blood relatives only.

Relation	Past and Present Health Problems	Age at time of death (if applicable)

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INFORMED CONSENT

I would like to take this opportunity to welcome you to the clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and supplemental therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history, which may include a physical exam and specific laboratory testing as part of the treatment. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

I, (printed name) _____ as a patient of this clinic, have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As the clinic is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest of therapies potentially have their complications in certain physiological conditions, in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture; and muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so declaring.

I understand that, as a patient, I am responsible for all costs incurred as a result of the decision including, but not limited to; the cost of all procedures involved in the treatment plan, the care provider's time, supplements, supplies and appointments missed or cancelled without sufficient notice (48 hours). I am aware that all telemedicine appointments will be charged to the credit card on file seven (7) days in advance of the appointment. I am aware that treatments are not covered through Alberta Health Care and may not be covered under private health insurance.

_____ _____

SIGNATURE **DATE**