Integrative Health Inc
Experts Providing Healthcare

Hyperbaric Oxygen therapy Chamber (HBOT) Questionnaire and Consents

5191 S. Yosemite St., Suite B, Greenwood Village, CO 80111

Patient Contact Information

Name: _____ Date: _____

DOB _____ Age: _____ ☐ Male ☐ Female If minor, name of parent: _____

Cell #_____

Complete the information below if it has changed since completing the initial intake form:

Address:_____City:_____ State:_____ Zip:_____

E-mail address: _____

Employer: _____ Occupation:_____

Married or have a life partner? ☐ Yes ☐ No Significant other's name: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

2nd Contact: _____ Relationship: _____ Phone:_____

Contraindications & Safety Screening

HBOT **may not be appropriate** if you currently have or have a history of:

- Pneumothorax (collapsed lung)
- Severe COPD/emphysema
- Optic neuritis
- Seizure disorders or low seizure threshold
- Active upper respiratory infection, sinus infection, or high fever
- Pregnancy

Medications that preclude HBOT:

- Doxorubicin (Adriamycin)
- Cisplatin, Bleomycin
- Disulfiram (Antabuse)
- Mafenide Acetate.

Please list current medications and supplements:

_____

Informed Consent & Liability Release

I understand that Hyperbaric Oxygen Therapy is considered investigational for many conditions and that **results are not guaranteed**. I acknowledge and accept all risks, known and unknown, associated with HBOT and agree to hold **Integrative Health Inc** harmless from any claims arising from my participation.

Possible risks and side effects may include:

- Ear or sinus pressure or pain
- Temporary vision changes
- Fatigue
- Blood sugar changes (diabetic patients)
- Oxygen toxicity or seizures (rare)

Disclaimer: Hyperbaric Oxygen Therapy is not FDA-approved for all conditions and is not intended to diagnose, treat, cure, or prevent disease. Integrative Health Inc does not provide medical diagnosis or accept insurance.

I have been informed about:

- Ear pressure equalization procedures
- Nutritional recommendations prior to treatment
- Smoking restrictions during treatment
- Special considerations for diabetes and seizure history

Mild Hyperbaric Therapy Acknowledgment

I understand that I must: - Communicate immediately if I experience ear pain, dizziness, anxiety, or discomfort - Avoid holding my breath during pressurization or depressurization - Inform staff of seizure history, diabetes, or chemical sensitivities

If I am insulin-dependent, I agree to monitor blood glucose before and after treatment and bring appropriate snacks into the chamber.

Initials: _____

Health Information Authorization

I authorize Integrative Health Inc to:

- Contact me regarding appointments and health-related information
- Leave voicemail messages if necessary
- Provide HBOT in an open treatment room

Initials: _____

I understand that HBOT is **not a substitute for medical care** and that I should consult my physician prior to treatment.

I understand, have read, and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. The treatments I receive here are voluntary and I release this institution and/or the skin care professional from liability and assume full responsibility thereof.

Printed Name:_____

Patient Signature: _____ Date: _____