

CLIENT INFORMATION

Today's date _____ Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date Of Birth: _____ Age: _____

Telephone number: _____ Email Address: _____

Emergency Contact Information:

Name/Relationship _____ Their telephone number _____

Known Allergies: (food, drugs, Vaccines, an/or environmental): _____

HBOT treatment will be denied if you are taking the following medications: Bleomycin, Disulfiram, Mafenide Acetate. HBOT treatment will be denied if you have or suspect the following: COPD, Hereditary Spherocytosis, and Sickle Cell Anemia

What is your primary reason for coming to Hyperbaric Med Spa? _____

How did you hear about Hyperbaric Med Spa? _____

Thank you for choosing Hyperbaric Med Spa