FISHER CHIROPRACTIC
SPORTS PERFORMANCE & FAMILY WELLNESS

HYPERBARIC OXYGEN CHAMBER

FISHER CHIROPRACTIC
SPORTS PERFORMANCE & FAMILY WELLNESS

CONTINUE ONLY IF:

Not currently prescribed or taking medications:

Bleomycin, Disulfiram, Mafenide Acetate

Do not have or suspect having:

Hereditary Spherocytosis, Sickle Cell Anemia, COPD

Patient Information:

*Date:*_____

*Name:*_____ *Birth Date:*_____/_____/_____
Address: _____
*City:*_____ *State:*_____ *Zip Code:* _____
Phone:(____)_____-_____ *Email Address:*_____

Check Appropriate Box:
[_]Minor [_] Single [_]Married [_] Divorced [_] Widowed [_]Separated

*If Minor, Parent or Legal Guardian:*_____

Person to Contact in Case of Emergency:
*Name:*_____ *Phone:* (____)_____-_____

What Is Your Primary Reason for Coming to Hyperbaric PHP?:

_____

Who May We Thank for Referring You?:

_____

Physician Information

Are You Currently Under a Doctor's Care? [_]*Yes [_] No*
*Physician's Name:*_____
Address: _____
*City:*_____ *State:*_____ *Zip Code:* _____
Phone:(____)_____-_____ *Email Address:*_____

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SPORTS PERFORMANCE & FAMILY WELLNESS

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Patient Medical History

1. Are you under medical treatment now? Yes No
2. Do you exercise on a regular basis? Yes No *If so, how often?*_____
3. Do you use tobacco? Yes No *If so, how many weeks?*_____
4. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No *If yes, please explain.*_____
5. Do you use alcohol? Yes No
6. Are you pregnant or think you may be pregnant? Yes No
7. Are you taking any medication(s)? Yes No *If yes, what medication(s) are you taking?*_____
*8. List any medications you are allergic to:*_____
9. Do you have, or have you had any of the following?

Acute Respiratory Illness	Yes	No
AIDS or HIV Infection	Yes	No
Frequent Ear Infections	Yes	No
Frequently Tired	Yes	No
Mitral Valve Prolapse	Yes	No
Neurological Disease	Yes	No
Anemia Glaucoma Radiation Therapy	Yes	No
Angina Hay Fever/Allergies	Yes	No
Anxiety	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Hepatitis/Jaundice	Yes	No
Heart Attack	Yes	No
Heart Disease	Yes	No
Recent Weight Loss	Yes	No
Respiratory Problems	Yes	No
Rheumatic Fever	Yes	No
Back Pain	Yes	No
Cancer	Yes	No
Heart Murmur	Yes	No
Heart Problems	Yes	No
Ringing in the Ears	Yes	No
Rosacea	Yes	No
Chemical Sensitivity	Yes	No

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SPORTS PERFORMANCE & FAMILY WELLNESS

INITIALS_____

HYPERBARIC OXYGEN CHAMBER

FISHER CHIROPRACTIC
SPORTS PERFORMANCE & FAMILY WELLNESS

Chest Pains	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No
Seizure Disorders	Yes	No
Stomach Problems/Ulcers	Yes	No
Chronic Bronchitis Infections	Yes	No
Frequent Stroke	Yes	No
Chronic Fatigue (CFS)	Yes	No
Claustrophobia	Yes	No
Kidney Disease	Yes	No
Leukemia	Yes	No
Swollen Ankles	Yes	No
Thyroid Problems	Yes	No
Diabetes – Insulin Dependent	Yes	No
Liver Disease	Yes	No
Tuberculosis	Yes	No
Emphysema	Yes	No
Low Blood Pressure	Yes	No
Fainting / Seizures	Yes	No
Fever-Related Seizures	Yes	No
Lung Disease	Yes	No
Lung Infection, Frequent	Yes	No
Fibromyalgia	Yes	No
Malignant Disease	Yes	No

*Other:*_____

10. Have you ever had any ear problems?	Yes	No
11. Do you have any problems with your ears when you fly?	Yes	No
12. Do you have any problems going up and down in an elevator?	Yes	No
13. Do you have back problems?	Yes	No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the release of any medical information from my chart to any physician or physicians who may be involved in my medical treatment. I understand it is my responsibility to update this information as needed. This includes changes in medical conditions/diagnosis, medications, and personal and physician contact information. I agree to be responsible for payment of all services rendered on me or my dependent's behalf.

Signature of patient (parent or guardian) _____

Date: _____ Doctor's Comments:_____

HYPERBARIC OXYGEN CHAMBER

FISHER CHIROPRACTIC
SPORTS PERFORMANCE & FAMILY WELLNESS

Hyperbaric Therapy Consent Form

The technology, known as mild Hyperbaric Therapy (mHBT or HBOT), has been reported to have beneficial effects for a wide range of conditions, without negative side effects. Nevertheless, as with many treatments, there are areas of concern that you should be aware of. You must take a few minutes to read the following information.

OTIC BAROTRAUMA*: This is a condition of injury to the eardrum and is extremely unlikely to occur in the mild hyperbaric chamber. However, severe ear discomfort can be caused if you cannot equalize the pressure in your ears. As the chamber is pressurized and depressurized you must be able to equalize the pressure in your ears to acclimate to the pressure changes. You will most likely experience "popping" in your ears. This is normal. You can assist the equalization process by yawning, chewing, swallowing, working your jaw side to side and up and down, and turning the head side to side and ear to shoulder. Sitting upright in the chamber during pressurization and depressurization will generally also make the equalization process more comfortable. In general, doing whatever assists you in being comfortable when taking off and landing in a plane may be most effective for you. Continue to do this as needed for the duration of pressurization and depressurization. When the chamber reaches full pressure and again when the chamber is completely deflated there should be no additional pressure in the ears****. IF YOU ARE UNABLE TO EQUALIZE EAR PRESSURE AND EXPERIENCE PAIN IN ONE OR BOTH EARS, YOU MUST COMMUNICATE ANY DISCOMFORT IMMEDIATELY TO THE STAFF.*** *This will allow us to make adjustments in the pressurization or depressurization process to eliminate discomfort. If you are unable to equalize the pressure in your ears the visit will be immediately terminated. If this happens or if pain persists beyond the visit, we recommend that you consult your physician to evaluate and alleviate the situation before attempting another visit.*

EAR, SINUS AND/OR THROAT CONGESTION, HEAD COLDS, VIRUS OR PRIOR TRAUMA TO THE EARS*: You may consider rescheduling your visit in the chamber if you are suffering from any of these conditions. Discomfort from these conditions is less frequent but may occur****. IF YOU ARE UNABLE TO EQUALIZE EAR PRESSURE AND EXPERIENCE PAIN IN ONE OR BOTH EARS, IT IS CRITICAL THAT YOU COMMUNICATE ANY DISCOMFORT IMMEDIATELY TO THE STAFF*** *so we can assist you or terminate your visit****.*** *We recommend you consult your physician to alleviate the underlying condition before attempting another visit.*

INITIALS_____

HYPERBARIC OXYGEN CHAMBER

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PULMONARY HYPER EXPANSION*: This condition is very rare under mild hyperbaric treatments. However, to be overly cautious,* ***HOLDING YOUR BREATH DURING DECOMPRESSION MUST BE AVOIDED*** *as it could lead to expansion of the air in your lungs and damage to the lung tissues. In the highly unlikely event of an unexpected rapid decompression, you must exhale immediately.*

MEDICATIONS*: Hyperbaric Therapy may enhance the effectiveness or increase the metabolism (decrease the effectiveness) of any medication you are taking.* ***IT IS RECOMMENDED THAT YOU HAVE THE DOSAGE AND FREQUENCY OF ALL MEDICATIONS MONITORED AND ADJUSTED REGULARLY BY YOUR PHYSICIAN****.*

PREGNANCY*:* ***MILD HYPERBARIC THERAPY IS NOT ALLOWED DURING THE FIRST TRIMESTER.*** *After this time, it may be beneficial to both mother and child.* ***INITIALS _____***

SEIZURES*: mild Hyperbaric Therapy is not associated with causing or inducing seizures. To be on the cautious side we have established a seizure protocol that involved reaching full pressure (4.2psi) and spending full treatment time (standard 1 hour) in the chamber over a series of staged visits****. IF ANYONE GETTING IN THE CHAMBER IS SEIZURE-PRONE, THE STAFF MUST BE MADE AWARE BEFORE THE FIRST VISIT.*** *If a seizure is experienced in our clinic, unless otherwise instructed (and a waiver is signed), our procedure is to call 911, remove the patient from the chamber, and make the individual as comfortable as possible.*

DETOXIFYING OR CELL DIE-OFF*: Hyperbaric Therapy may assist the body to naturally detoxify and balance digestive flora.* ***AN INDIVIDUAL MAY EXPERIENCE SOME DISCOMFORT FROM THIS PROCESS IN AS LITTLE AS 1 TO 36 HOURS AFTER TREATMENT****. Symptoms may include flu-like symptoms, loss of appetite, stomachache, constipation, diarrhea, headache, behavioral issues, etc. Although unpleasant, this is a natural process and continuing treatments may be of benefit to more rapidly accomplish a positive result. However,* ***IF SYMPTOMS PERSIST, WE RECOMMEND CONSULTING YOUR PHYSICIAN TO EVALUATE AND ALLEVIATE THE SITUATION BEFORE ATTEMPTING ANOTHER VISIT****.*

PNEUMOTHORAX*: Hyperbaric Therapy is contraindicated for an existing pneumothorax (collapsed lung).* ***IF YOU HAVE A PNEUMOTHORAX OR SUSPECT THAT A PNEUMOTHORAX IS AN ISSUE, YOU WILL NOT BE ALLOWED IN THE CHAMBER UNTIL YOU/WE RECEIVE A DOCTOR'S CLEARANCE.*** *If you have experienced a pneumothorax in the past and have already been "cleared by your doctor" to resume normal activity, once you have provided a written confirmation you should be able to proceed with mild Hyperbaric Therapy you should be able to proceed with mild Hyperbaric Therapy.*

INITIALS_____

FISHER CHIROPRACTIC
SPORTS PERFORMANCE & FAMILY WELLNESS

HYPERBARIC OXYGEN CHAMBER

FISHER CHIROPRACTIC
SPORTS PERFORMANCE & FAMILY WELLNESS

COMPRESSIVE BRAIN LESIONS – SUBDURAL HEMATOMA, INTRACRANIAL HEMATOMA*: Hyperbaric Therapy is contraindicated for existing compressive brain lesions (subdural hematoma, intracranial hematoma).* ***IF YOU HAVE COMPRESSIVE BRAIN LESIONS OR SUSPECT THAT COMPRESSIVE BRAIN LESIONS ARE AN ISSUE, YOU WILL NOT BE ALLOWED IN THE CHAMBER UNTIL YOU/WE RECEIVE A DOCTOR'S CLEARANCE.*** *If you have experienced compressive brain lesions in the past and have already been "cleared by your doctor" to resume normal activity, once you have provided a written confirmation you should be able to proceed with mild Hyperbaric Therapy.*

DIABETES / INSULIN DEPENDENT*: Insulin dependency may result in a drop in blood sugar while in the chamber.* ***IT IS CRITICAL THAT YOU IMMEDIATELY COMMUNICATE TO THE STAFF IF YOU EXPERIENCE OR ANTICIPATE AN EPISODE. YOUR TREATMENT WILL BE TERMINATED.*** *You are required to; A) take a blood sugar reading before your treatment (if below 150, you must have a snack before treatment) and again after your treatment (if below 150, you must have a snack before leaving). B) Take a protein bar and a juice box (or whatever you use if faced with a "drop" in the normal management of your condition) into the chamber with you.*

SENSITIVITY TO CHEMICALS (MCS) / ODORS / ALLERGY*: Avoid wearing heavy colognes as the smells may linger in the chamber and have an adverse effect on another patient****. IF YOU EXPERIENCE ADVERSE SENSITIVITY OR HAVE ALLERGIES THAT MAY BECOME AGGRAVATED WHILE IN THE CHAMBER, LET THE STAFF KNOW BEFORE YOU VISIT OR AS SOON AS POSSIBLE WHEN IN THE CHAMBER SO MEASURES CAN BE TAKEN TO ASSURE YOUR COMFORT OR IF YOUR VISIT NEEDS TO BE TERMINATED.*** *We recommend that you wear a charcoal mask or filter if it is known to assist your condition. If these sensitivities persist and you cannot exist comfortably in the chamber, you will need to consult your physician to alleviate the underlying condition before attempting another visit.*

I have read and fully understand the above information

Signature _____ Date: _____/_____/_____

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SPORTS PERFORMANCE & FAMILY WELLNESS

INITIALS_____

FISHER CHIROPRACTIC
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HYPERBARIC OXYGEN CHAMBER

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SPORTS PERFORMANCE & FAMILY WELLNESS

The patient acknowledges the following:

Although mild hyperbaric therapy has been reported to be beneficial for a wide range of conditions, this therapy is not meant as a cure for any condition or disease and no therapeutic outcomes can be guaranteed. We do not in any way recommend hyperbaric therapy as a substitute for any medical treatments prescribed or suggested by any medical physician. We do not make any guarantees to any results that an individual may experience. We do not accept insurance for our services.

Signature _____ Date: _____/_____/_____

HEALTH INFORMATION AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES FISHER CHIROPRACTIC TO USE AND / OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I permit Fisher Chiropractic to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday-related information, treatment alternatives, or other health-related information.

Initial _____

I permit Fisher Chiropractic to leave a phone message on my answering machine or voice mail.

Initial _____

I permit Fisher Chiropractic to provide hyperbaric therapy in an open room where other patients are also receiving other therapies. I am aware that other persons in the office may overhear some of my protected health information during care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

Initial _____

Signature _____ Date:_____/_____/_____

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SPORTS PERFORMANCE & FAMILY WELLNESS

INITIALS_____

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SPORTS PERFORMANCE & FAMILY WELLNESS

HYPERBARIC OXYGEN CHAMBER

FISHER CHIROPRACTIC
SPORTS PERFORMANCE & FAMILY WELLNESS

PROMOTION AND DOCUMENTATION AUTHORIZATION FORM

To assist in the promotion and documentation of our services here at the center, we request
SPECIFIC AUTHORIZATIONS

I permit Fisher Chiropractic to use my photograph or my child's photograph in printed form on display at the center or during promotional events.

Initial _____

I permit Fisher Chiropractic to use all or part of my testimonial in printed form on display at the center or during promotional events.

Initial _____

By signing this form, you are giving Fisher Chiropractic permission to use and disclose your protected health information by the directive listed above. You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Fisher Chiropractic will not refuse to provide treatment. You have the right to revoke this AUTHORIZATION at any time in writing. Details will be provided upon your request.

Signature _____ Date: _____/_____/_____

FISHER CHIROPRACTIC
SPORTS PERFORMANCE & FAMILY WELLNESS