



Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

Office: 623-252-0376
Fax: 623-399-1059



Hyperbaric Oxygen [HbO2] Patient Intake Form

Page 1 of 6

Personal Information

Name _____ Age _____ Date of Birth _____
Height _____ Weight _____ Gender Male Female
Address _____
City _____ State _____ Zip _____

Married Home Phone _____
 Divorced Cell Phone _____
 Single Work Phone _____
 Widow Email Address _____
Children _____

Would you like to be subscribed to our newsletter? [no more than 1-2 emails per month] Our newsletter includes health-related articles, Medical Marijuana announcements, and healthy recipes. Y N

Spouse _____ Phone _____
Emergency Contact _____ Phone _____

Occupation: _____ FT PT
Employer: _____

Primary Care Physician _____ Phone _____
Is it okay if we contact them about your care? Y N

How did you learn about our office?

Attorney Family Google Other _____
 Mailer Co-worker Yelp _____
 Friend Physician Facebook _____

If referred, by whom: _____

Signature Patient _____ Patient Name [Printed] _____ Date _____

If needed, Signature of authroized representative _____ Representative Name [Printed] _____ Relationship to patient _____ Date _____

Authorized Facility Signature _____ Date _____



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Page 2 of 6

Medical History

Current Medical Complaint

Allergies

No Known Allergies Yes - Know Allergies - List All Medications, Foods, Environmental Allergies

Medications [please include prescription, herb and over-the-counter]

No Current Medications Yes - Current Medications Listed

			Oral	Injection	Topical	Other	
Medication: _____	Dose: _____	Route: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication: _____	Dose: _____	Route: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication: _____	Dose: _____	Route: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication: _____	Dose: _____	Route: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication: _____	Dose: _____	Route: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication: _____	Dose: _____	Route: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication: _____	Dose: _____	Route: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

If you have a long list, please feel free to bring in a sheet listing all your medications.

Surgeries

No Surgeries Yes - List surgeries below

Surgery	Month	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Page 3 of 6

Medical History [continued]

Please Check YES or NO for ALL of the following regarding your health

- | | | |
|--|---|--|
| Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Temperature/Pressure Sensitivity | <input type="checkbox"/> <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease / Circulatory Issues [explain] _____ | <input type="checkbox"/> <input type="checkbox"/> Abnormal weight <input type="checkbox"/> Loss <input type="checkbox"/> Gain | <input type="checkbox"/> <input type="checkbox"/> Stress |
| _____ | <input type="checkbox"/> <input type="checkbox"/> Thyroid <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper | <input type="checkbox"/> <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> <input type="checkbox"/> Stroke [date] _____ | <input type="checkbox"/> <input type="checkbox"/> Bruise easily / Bleeding problems | <input type="checkbox"/> <input type="checkbox"/> Headaches |
| <input type="checkbox"/> <input type="checkbox"/> Cancer / Tumor [explain] _____ | <input type="checkbox"/> <input type="checkbox"/> Unusual Spots / Moles | <input type="checkbox"/> <input type="checkbox"/> HIV / AIDS |
| _____ | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> <input type="checkbox"/> Wear Contacts |
| <input type="checkbox"/> <input type="checkbox"/> Osteoporosis/Osteopenia [where] _____ | <input type="checkbox"/> <input type="checkbox"/> Corticosteroid Use | <input type="checkbox"/> <input type="checkbox"/> Night sweats |
| _____ | <input type="checkbox"/> <input type="checkbox"/> Hives, Eczema, Rash | <input type="checkbox"/> <input type="checkbox"/> Recent fever |
| <input type="checkbox"/> <input type="checkbox"/> Taking Birth Control _____ | <input type="checkbox"/> <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> <input type="checkbox"/> STD _____ | <input type="checkbox"/> <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> <input type="checkbox"/> Substance Abuse _____ | <input type="checkbox"/> <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> <input type="checkbox"/> Mental Health Problems _____ | <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> <input type="checkbox"/> ADD / ADHD |
| _____ | <input type="checkbox"/> <input type="checkbox"/> Dizziness / Fainting | |
| <input type="checkbox"/> <input type="checkbox"/> Sleep Disorders [Sleep apnea, insomnia] | <input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizures | |
| <input type="checkbox"/> <input type="checkbox"/> Broken bones / Fractures: _____ | <input type="checkbox"/> <input type="checkbox"/> History of Head Injury | |
| <input type="checkbox"/> <input type="checkbox"/> Surgeries / Hospitalizations: _____ | <input type="checkbox"/> <input type="checkbox"/> Intestinal Disorders [IBS, Ulcers] | |
| <input type="checkbox"/> <input type="checkbox"/> Other health related issues: _____ | <input type="checkbox"/> <input type="checkbox"/> Asthma / Lung Disease / Difficulty Breathing | |
| | <input type="checkbox"/> <input type="checkbox"/> Last physical date _____ | |

Female Patients Only

- | | | |
|----------------------------------|---|---------------|
| | Y N | |
| Are you pregnant? | <input type="checkbox"/> <input type="checkbox"/> | # Weeks _____ |
| Are you currently breastfeeding? | <input type="checkbox"/> <input type="checkbox"/> | |

Physical / Social History

- | | | |
|---|--|---|
| Exercise | Work Activity | Drug and Alcohol History |
| <input type="checkbox"/> None | Y N | Y N |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> <input type="checkbox"/> Sitting | <input type="checkbox"/> <input type="checkbox"/> Tobacco Cigaretts / day _____ |
| <input type="checkbox"/> Heavy | <input type="checkbox"/> <input type="checkbox"/> Standing / Bending | <input type="checkbox"/> <input type="checkbox"/> Alcohol Drinks / week _____ |
| Days/week: _____ | <input type="checkbox"/> <input type="checkbox"/> Light Labor | <input type="checkbox"/> <input type="checkbox"/> Caffeine Drinks / day _____ |
| | <input type="checkbox"/> <input type="checkbox"/> Heavy Labor | <input type="checkbox"/> <input type="checkbox"/> Cocaine / Meth |
| General | | <input type="checkbox"/> <input type="checkbox"/> Opiates/Prescription, heroin or methadone |
| Y N | | <input type="checkbox"/> <input type="checkbox"/> Hallucinogens [Ecstasy, LSD, Mushrooms] |
| <input type="checkbox"/> <input type="checkbox"/> High Stress _____ | | <input type="checkbox"/> <input type="checkbox"/> Other _____ |
| | | Would you like help quitting? Y N NA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

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Page 4 of 6

Medical History [continued]

Family History

Mother's Side

Y N

Cancer [type] _____

Heart Disease - Age _____

Stroke - Age _____

High Blood Pressue

Diabetes

Rheumatoid Arthritis

Other _____

Father's Side

Y N

Cancer [type] _____

Heart Disease - Age _____

Stroke - Age _____

High Blood Pressue

Diabetes

Rheumatoid Arthritis

Other _____

Cancellation Policy

To better serve our patients, we require 24-hour notice if an appointment is to be canceled or rescheduled. This will ensure maximum availability to all patients who need to see us.

We will charge a \$50 fee for any appointment canceled or rescheduled with less than 24-hours notice.

Prescription Refill Policy

Burns Integrative Wellness Center will call in prescription refills within 48 hours of receiving the request on business days, Monday through Friday, except for holiday schedules. Please plan your refills accordingly.

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

Signature Patient Patient Name [Printed] _____ Date _____

If needed, Signature of authroized representative Representative Name [Printed] Relationship to patient Date _____

Authorized Facility Signature Date _____

