

PURSUING HEALTH

# VIBRANT KIDS

PEDIATRICS

PRELIMINARY QUESTIONNAIRE FOR A PROSPECTIVE HYPERBARIC OXYGEN THERAPY PATIENT

## Hyperbaric Oxygen Therapy Patient Questionnaire

We ask that you fill out this brief questionnaire before scheduling your initial Hyperbaric Oxygen Therapy (HBOT) evaluation with our office. When reviewed by our physician, we will contact you to schedule the initial evaluation and 20-minute test dive.

### Demographics

#### Patient

\_\_\_\_\_  
Patient's name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Gender

\_\_\_\_\_  
Weight

lb

\_\_\_\_\_  
Height

ft

\_\_\_\_\_  
in

#### Mailing Address

\_\_\_\_\_  
street 1

\_\_\_\_\_  
street 2

\_\_\_\_\_  
city

\_\_\_\_\_  
state

\_\_\_\_\_  
zip code

#### Parent / Legal Guardian #1

\_\_\_\_\_  
Parent/guardian name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
phone number

\_\_\_\_\_  
email

Relationship to patient: \_\_\_\_\_



# Hyperbaric Oxygen Therapy Patient Questionnaire

Vibrant Kids Pediatrics

## Parent / Legal Guardian #2

\_\_\_\_\_  
Parent/guardian name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
phone number

\_\_\_\_\_  
email

Relationship to patient: \_\_\_\_\_

List all healthcare providers: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What medical issue(s) are you hoping to improve with HBOT?

- |  |  |
|--|--|
| <input type="checkbox"/> PANDAS/PANS                   | <input type="checkbox"/> Lyme                      |
| <input type="checkbox"/> Autism                        | <input type="checkbox"/> Musculoskeletal disorders |
| <input type="checkbox"/> Athletic performance/recovery | <input type="checkbox"/> Concussion                |
| <input type="checkbox"/> Other: _____                  |  |

Have you had any surgical procedures?

- Yes    No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you experienced any type of head injury?

- Yes    No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# Hyperbaric Oxygen Therapy Patient Questionnaire

Vibrant Kids Pediatrics

Have you had any past/recurrent ear trauma?

- Yes    No

If yes, please describe: \_\_\_\_\_

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Do you have high blood pressure or other cardiovascular issues?

- Yes    No

If yes, please describe: \_\_\_\_\_

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Do you have any respiratory issues such as asthma, emphysema, sinusitis, or chronic rhinitis?

- Yes    No

If yes, please describe: \_\_\_\_\_

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Do you have any mobility difficulties requiring assistance entering or exiting the HBOT chamber?

- Yes    No

If yes, please describe: \_\_\_\_\_

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Are you claustrophobic?

- Yes    No

