



Hyperbaric Oxygen Therapy Approval Form

Complete fillable PDF form and save. Return to email jasonstonefitness@gmail.com

Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Reason for Hyperbaric Oxygen Therapy/Medical Condition:

Please mark any of the following conditions that you have or have had:

- | | |
|--|---|
| <input type="checkbox"/> Inner ear problems | <input type="checkbox"/> Difficulty Clearing Ears |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Acute Cold (Congestion) |
| <input type="checkbox"/> Chronic Infections | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Sinus Issues | <input type="checkbox"/> Stroke |

Please list any medications that you are currently taking or have taken within the last 2 weeks:

Please list any known allergies:

Please list any recent surgeries:

Please list any other medical information that you feel is important for the doctor to know:

Please expect at least 48 hours for an approval. If approval is not given, please schedule an appointment with Physician, Physician Assistant, Chiropractor or Dr. Krueger for a consultation.

X _____ Date:* _____

Client/Parent/Legal Guardian

X _____ Date:* _____

Physician, Physician Assistant, Chiropractor Approval X _____