KK Hyperbaric Health Center

New Customer Registration Form

First Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of

Birth : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies/Health condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Questionnaires for Floating Bath

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| --- | --- | --- |
| 1 | Are you suffering from any mental illness for which you may or may not be under the supervision of a psychiatrist? (Sensory deprivation may induce hallucination). | Yes /No |
| 2 | Are you suffering from epilepsy? | Yes/ No |
| 3 | Are you suffering from hypotension? (low blood pressure) | Yes/ No |
| 4 | Are you suffering from urinary or stool incontinence? | Yes/ No |
| 5 | Are you taking any medication for any medical illnesses?  If yes,   1. What are those medications?   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Have you discussed with your doctor regarding sensory deprivation therapy with your doctor? | Yes/No    Yes/No |
| 6 | Are you having your menstrual period at the moment? ( Females) | Yes/No |
| 7 | Are you under the influence of alcohol or drugs at the present moment? | Yes/No |
| 8 | Have you consumed caffeine or energy drinks in the past 2-3 hours? | Yes/No |

Questionnaires for PEMF Therapy

|  |  |  |
| --- | --- | --- |
| 1 | Are you pregnant? (Contraindication) | Yes/No |
| 2 | Do you have any organ transplant? (Contraindication) | Yes/No |
| 3 | Do you have a cardiac pacemaker? (Contraindication) | Yes/No |
| 4 | Do you have cochlear implant? (Contraindication) | Yes/No |
| 5 | Do you have an intrathecal pump? (Contraindication) | Yes/No |
| 6 | Do you have an implanted defibrillator? (Caution) | Yes/No |
| 7 | Do you have an active bleeding disorder? (Caution) | Yes/No |
| 8 | Do you have grave’s disease? (Caution) | Yes/No |
| 9 | Do you have any metallic implants? (Caution) | Yes/No |
| 10 | Do you have breast implants? (Caution) | Yes/No |