



# Richmond Hyperbaric Health Center

## CLIENT / ATTENDANT FORM

Client's Name \_\_\_\_\_  
(First) (Initial) (Last)

Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
(Y/M/D)

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

City: \_\_\_\_\_ Province/State: \_\_\_\_\_

Country: \_\_\_\_\_ Postal Code/Zip: \_\_\_\_\_

Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_

Please describe Primary Diagnosis, All Medications presently taken, and concurrent therapies.

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

**A family physician or physician is aware of your condition.**

Physician \_\_\_\_\_ Clinical / Hospital \_\_\_\_\_

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

Postal Code: \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_