Personal Details Form

Contact Information	
First name:	**Last name:**
Email address:	
Date of birth:	
Full Address:	
Telephone:	
Mobile number:	
Health Information	
Are you showing signs, symptoms of any infectious conditions including Covid 19?	
Have you ever suffered a pneumothorax, collapsed lung, gas embolism or barotrauma of the ear?	
Do you have trouble with your sinuses e.g. blocked nose or ears?	
Do you have any concerns about your ears?	
Do you suffer from claustrophobia?	

Do you have any medical implants e.g. pacemaker?
Have you had a seizure in the last year?
What is the reason you are undertaking this treatment? (e.g. sports injury, general health and wellbeing)
Are you on any of the following drugs? ● **Adriamycin, bleomycin or any other ending 'mycin'** ● **Vincristine, leurocristin or any other ending in 'cristin'** **If yes, please state:**
Who would you like us to contact in the event of an emergency? Please fill out details below.
First Contact

Name:	**Relationship to you:**
Telephone number:	**Mobile number:**

Second Contact (if applicable)

Name:	**Relationship to you:**
Telephone number:	**Mobile number:**

Where did you hear about us?
☐ **Word of mouth or referral** ☐ **Online search** ☐ **Social media (Facebook, Instagram etc.)** ☐ **Magazine or newspaper** ☐ **Radio** ☐ **Other (please specify):**
Declaration

I declare that the information I have given above is to the best of my knowledge.	
Signed:	**Date:**