



## Hyperbaric Oxygen Therapy (HBOT)

### Client Disclaimer & Pre-Treatment Questionnaire

Before undergoing Hyperbaric Oxygen Therapy, it's important that we assess your suitability and ensure you are fully informed about the treatment, its benefits, potential risks, and any relevant medical considerations.

Please complete this form carefully and honestly. Once completed, you can either:

- **Email the form to:** [maria@youmatteruk.com](mailto:maria@youmatteruk.com) or
- **Bring a printed copy with you to your appointment**

This information helps us provide you with the safest and most appropriate care possible. If you have any questions while completing the form, please don't hesitate to contact us.

### 1. Explanation of Hyperbaric Oxygen Therapy

Hyperbaric Oxygen Therapy (HBOT) involves breathing pure oxygen in a pressurised environment. It increases oxygen levels in your blood and tissues to promote healing and reduce inflammation.

### 2. Potential Benefits

- Enhanced wound healing
- Reduced swelling and inflammation
- Increased oxygen supply to tissues
- Potential support in treatment of conditions such as:
  - Decompression sickness
  - Non-healing wounds
  - Radiation injuries

### 3. Potential Risks and Side Effects

While HBOT is generally safe, potential risks include:

- Barotrauma (injury from pressure changes)
- Temporary vision changes (e.g., short-sightedness)
- Fatigue or light-headedness
- Oxygen toxicity (rare)
- Claustrophobia or anxiety during the procedure

### 4. Contraindications

HBOT may not be suitable for individuals with:

- Untreated pneumothorax (collapsed lung)
- Certain lung diseases or respiratory issues
- High fever

- History of seizures or epilepsy
- Pregnancy (consult your physician)

## 5. Pre-Treatment Instructions

- Avoid perfumes, oils, or flammable products
- Remove jewellery, watches, and electronics
- Notify staff of any cold, flu, or fever
- You must Inform the practitioner of any medications or supplements

## 6. Consent Confirmation

I confirm I have been advised of and fully understand the following:

- The aims and desired outcomes of the procedure
- The inherent risks of the procedure and of refusing treatment
- Risks specific to me
- Expected benefits and possible disadvantages
- Alternative procedures and the option of no treatment
- Uncertainties and likelihood of success
- Any required follow-up treatment

## 7. Clinical Photos and Videos

I agree to and authorise the taking of clinical photographs and videos. I understand they will be stored securely as part of my confidential medical record.

## 8. Informed Decision

I have been:

- Offered all necessary information to make an informed decision
- Given the opportunity to discuss desired outcomes
- Able to ask all questions and receive satisfactory answers
- Not informed of any new risk information that changes my consent

## 9. Consent Declaration

I hereby consent to this procedure. I understand this constitutes full disclosure and supersedes any prior agreements. All deposits and booking fees are non-refundable unless otherwise agreed with the practitioner.

## 10. Client Questionnaire

Question	Yes	No	Comment
Do you understand the information you have been provided?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you feel sufficient information has been provided to you, to enable you to consent?	<input type="checkbox"/>	<input type="checkbox"/>	
Has your consent been freely given?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any medical conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	

Question	Yes	No	Comment
Do you have a neuromuscular disease (e.g., MS, ALS, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have an autoimmune disease?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any skin conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any known allergies or have ever had anaphylaxis?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any active infection at the intended site of procedure?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking antibiotics or other prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there any other medical and/or social history we should know?	<input type="checkbox"/>	<input type="checkbox"/>	
What are your aims/motivations and desired outcome for the procedure?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had this or similar treatment before? If so, any issues?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any concerns?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there anything else we should know?	<input type="checkbox"/>	<input type="checkbox"/>	
I will retain this information and refer to it during treatment.	<input type="checkbox"/>	<input type="checkbox"/>	

**Client Name:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_