Aquatic Fitness, Inc.

REGISTRATION FORM

(Please Print)

Today's date:											
PATIENT INFORMATION											
Last Name:		First Name:		Middle Initial:							
Birth Date:		Email:		Height:		Weight:					
Street address:		City:		State:		Zip:					
Home Phone:		Cell Phone:		Next Appt (with referring doctor):							
Date of Injury:		How did your injury occur?									
Previous Treatment:											
Diagnostic Tests:											

MEDICAL HISTORY				
Do you currently have or have you ever had any of the following? (please check all that apply)				
❑ Afraid of water	❑ Chemotherapy/Radiation	❑ Gout	❑ Infectious Disease	❑ Shortness of Breath
❑ Allergies/Pool Chemicals	❑ Chronic Diarrhea	❑ Hearing Difficulties	❑ Open Wounds	❑ Sleeping Problems
❑ Angina (chest pain)	❑ Currently Pregnant	❑ Heart Attack/Problems	❑ Osteoporosis	❑ Stroke
❑ Arthritis	❑ Currently Smoke	❑ Heart Surgery	❑ Pacemaker	❑ Thyroid Problems
❑ Asthma	❑ Diabetes	❑ Hernia	❑ Pins or Metal Implants	❑ Urinary Tract Infection
❑ Bladder Leakage	❑ Dizziness	❑ High Blood Pressure	❑ Psychological Problems	❑ Weight Loss
❑ Blood Clot	❑ Emphysema	❑ Joint Replacement	❑ Scoliosis	❑ Other (list)
❑ Bowel Leakage	❑ Fibromyalgia	❑ Kidney Problems	❑ Severe Headaches	
❑ Cancer	❑ Frequent Fainting	❑ Knee Problems	❑ Seizures/Epilepsy	

Have you ever had an injury or surgery on any of the following?								
	Injury	**Surgery**		**Injury**	**Surgery**		**Injury**	**Surgery**
Foot:	❑	❑	Back:	❑	❑	Elbow:	❑	❑
Ankle:	❑	❑	Hand:	❑	❑	Shoulder	❑	❑
Knee:	❑	❑	Wrist:	❑	❑	Neck:	❑	❑

List any other specific medical history:													
List all surgeries in the past 2 years:													
Have you fallen in the past year? ❑ Yes ❑ No				If yes, how many times?					Were you injured? ❑ Yes ❑ No				
List current medication with dosage (Including prescription, OTC, herbals, vitamins/supplements):													
Name of Employer:				Time at Employer:				Job Title/Description:					
Are you presently working? ❑ Yes ❑ No			❑ Light Duty ❑Full Duty			Hours per Day:			Last Day of Work:				
List any Restrictions:													
What is your vocational goal or your personal goal for therapy?													
Describe your pain Symptoms/Locations/Type													
Pain Scale (Circle One):	**Least**	0	1	2	3	4	5	6	7	8	9	10	**Most**
What makes your symptoms worse?													
What makes your symptoms better?													
Functional/Mobility Limitations?									Is there an attorney involved? ❑ Yes ❑ No				

IN CASE OF EMERGENCY		
Name :	Relationship to Patient:	Home Phone:
Patient/Guardian signature:	Date:	