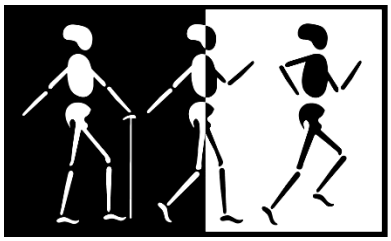
Advance Physical &



Aquatic Therapy

Patient Name	Date of Birth
Reason for Therapy	Date of injury onset
Have you ever received therapy for the condition mentioned above? ☐ Yes ☐ No	If so, when?
Treatment Received:	Previous Treatment: ☐ Successful ☐ Unsuccessful

Do you now or have you ever had any of the following?

Condition:	**Y**	**N**	**Condition:**	**Y**	**N**	**Condition:**	**Y**	**N**
Arthritis	☐	☐	Diabetes	☐	☐	Thyroid Problems	☐	☐
Osteoporosis	☐	☐	Anemia	☐	☐	Headaches	☐	☐
High Blood Pressure	☐	☐	Hypersensitivity to Heat/Cold	☐	☐	Head Injury / Concussion	☐	☐
Heart Disease	☐	☐	Swelling in Ankles	☐	☐	Hernia	☐	☐
Heart Attack	☐	☐	Deep Vein Thrombosis (DVT)	☐	☐	Kidney/Bladder Problems	☐	☐
Pacemaker	☐	☐	Seizures/Epilepsy	☐	☐	Previous Surgeries	☐	☐
Vascular Disease	☐	☐	Metal in Body or Surgical Implants	☐	☐	Hearing Loss	☐	☐
Stroke	☐	☐	Cancer/Tumor	☐	☐	Depression	☐	☐
Asthma	☐	☐	Current infection(s)	☐	☐	Anxiety	☐	☐
Shortness of Breath	☐	☐	Tuberculosis	☐	☐	Substance Abuse	☐	☐
Recent Weight Loss or Gain	☐	☐	Hepatitis	☐	☐	Other	☐	☐
Chronic Cough	☐	☐						
Fainting Spells	☐	☐						

If you answered "yes" on any of the above, please explain and give approximate date(s):

Do you have any allergies? ☐ Yes ☐ No. If yes, please list allergies:

Are you presently taking any medications? ☐ Yes ☐ No. If yes, please list and specify condition.

The information is correct to the best of my knowledge.

X

Patient/Parent/Guardian Signature	Date

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