



## Aquatic Fitness, Inc. Patient Registration

Date:		Home Phone:		Cell Phone:	
Name:		SSN #:		Birth Date:	
Address:		City/State/Zip:			
Employer:			Time at employer:		
Job title/Description:					
Are you presently working: <input type="checkbox"/> Yes		Hours per day:		<input type="checkbox"/> No	
<input type="checkbox"/> Light duty <input type="checkbox"/> Full duty		Last day of work:			
List any restrictions:					
What do you consider your most difficult task at work?					
How did your injury/episode occur?					
Date of injury:		Have you had surgery for this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date:	
List any other tests or treatment related to this injury?					
What makes your symptoms worse?					
What makes your symptoms better?					
Is there an attorney involved? (for medical records release): <input type="checkbox"/> Yes <input type="checkbox"/> No					

### Medical History

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Do you currently or have you ever had any of the following?** (Please check all that apply)

<input type="checkbox"/> Afraid of water	<input type="checkbox"/> Coronary heart disease	<input type="checkbox"/> Hearing difficulties	<input type="checkbox"/> Psychological problems
<input type="checkbox"/> Allergies	<input type="checkbox"/> Currently pregnant	<input type="checkbox"/> Heart attack/problems	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Allergies/pool chemicals	<input type="checkbox"/> Currently smoke	<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Severe headaches
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hernia	<input type="checkbox"/> Seizures
<input type="checkbox"/> Angina (chest pain)	<input type="checkbox"/> Dizziness	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emboli	<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Sleeping problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bladder leakage	<input type="checkbox"/> Emotional problems	<input type="checkbox"/> Knee problems	<input type="checkbox"/> Swollen joints
<input type="checkbox"/> Blood clot	<input type="checkbox"/> Energy loss	<input type="checkbox"/> Infectious disease	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Bowel leakage	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Urinary tract infection
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Open wounds	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Fainting	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Vision difficulties
<input type="checkbox"/> Chemotherapy/Radiation	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Weakness
<input type="checkbox"/> Chronic diarrhea	<input type="checkbox"/> Gout	<input type="checkbox"/> Pins or metal implants	<input type="checkbox"/> Weight loss

**Have you ever had an injury or surgery on any of the following?**

	Injury	Surgery		Injury	Surgery		Injury	Surgery
Foot:	<input type="checkbox"/>	<input type="checkbox"/>	Back:	<input type="checkbox"/>	<input type="checkbox"/>	Elbow:	<input type="checkbox"/>	<input type="checkbox"/>
Ankle:	<input type="checkbox"/>	<input type="checkbox"/>	Hand:	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder:	<input type="checkbox"/>	<input type="checkbox"/>
Knee:	<input type="checkbox"/>	<input type="checkbox"/>	Wrist:	<input type="checkbox"/>	<input type="checkbox"/>	Neck:	<input type="checkbox"/>	<input type="checkbox"/>

Have you fallen in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how many times?		Were you injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List any other specific medical history:					
List all surgeries in the past 2 years:					
List current medications with dosage (including prescription, OTC, herbals, vitamins/supplements):					
What are your goals for this rehab program?					
Emergency Contact:		Relationship:		Phone #:	
<b>Date of next appointment with referring physician:</b>					

Patient Signature: \_\_\_\_\_

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