

HEALTH QUESTIONNAIRE FOR AQUATIC & PHYSICAL THERAPY

NAME: _____

DATE: _____

Height: _____

Weight: _____

Age: _____

Name of Family Physician: _____

Date/Reason last consulted: _____

PERSONAL HEALTH HISTORY:

Please ✓ if you currently have or have ever had any of the following:

Please clarify w/ important details in the empty space to the right of the list ↓

- | | |
|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Orthopedic problems/fractures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Insulin Diabetes | <input type="checkbox"/> TMJ Problems |
| <input type="checkbox"/> Non-Insulin Diabetes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Valve Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Viral infection |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Cancer/Tumors |

List any medications you are currently taking (for example high blood pressure medication, insulin, required use of an inhaler due to asthma, pain medications).

Are you currently exercising? No Yes If yes, explain _____

Has a physician ever advised you against exercise? No Yes

If yes, why and when? _____

Level of Swimming Experience (please check one)

Non swimmer Hydrophobic Beginner Intermediate Advanced

Are you affected by increased temperatures, specifically between 88° to 92°? No Yes

List any serious health problems which would limit you in any way to perform gym exercises or aquatic exercises.

List any recent operations other than that which you are currently being treated for:

Are you on a diet? No Yes If yes, please describe: _____

When was your last physical examination? _____

Are you presently under another doctor or other healthcare professional's care? No Yes

Name: _____ Type of practitioner or doctor _____

Reason: _____

SOCIAL HABITS

| Indicate usage: | Heavy | Moderate | Light | None |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Weekly sugar intake | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Weekly Caffeine intake | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco: Chewing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Smoking* | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*List # of packs per day _____