MILLS PENINSULA HEALTH SERVICES

AQUATIC INTAKE FORM

☐ Exercise Class ☐ Independent ☐Aquatic Bodywork (WATSU)

Date:	
Name:	Date of Birth:
Address: City	
Home Phone:	Work Phone:
Diagnosis:	
Primary Care Physician:	Phone:
Consulting/Referring MD:	Phone:
Emergency Contact:	Phone:

Can you swim well enough to save your own life? ☐ YES ☐ NO

Are you afraid of the water? ☐ YES ☐ NO

Have you been through aquatic physical therapy at Mills Health Center before? ☐ YES ☐ NO If yes, name of therapist _____

Do you have any of the following conditions or limitations?

- ☐ Contagious disease
- ☐ Open lesions/wounds
- ☐ Tracheotomy
- ☐ Seizure
- ☐ Epilepsy
- ☐ Stroke/CVA Date:_____
- ☐ Dizziness
- ☐ External tubes/leads
- ☐ Urinary Tract Infection
- ☐ Hearing aids/Contact Lenses
- ☐ Swallowing Difficulties
- ☐ Bowel/Bladder Control
- ☐ Undergoing radiation treatment
- ☐ Stress, Anxiety, Depression
- ☐ Sensitive to Bromine
- ☐ Overweight (20 lbs > IBW)
- ☐ Limited weight bearing
- ☐ Pregnant Due Date:_____

EXERCISE STATUS:

- ☐ Sedentary (no exercise)
- ☐ Minimal (1-2 days per week)
- ☐ Moderate (3-4 days per week)
- ☐ Very Active (> 5 days per week)

Type of Exercise:_____

Please answer the following questions as accurately as possible:

1) Do you have any physical limitations?
   Explain:_____

2) Do you have (Have you had) any back, neck, or torso injuries or strains?
   Explain:_____

3) Do you have (Have you had) any shoulder, arm, wrist or hand injuries or strains?
   Explain:_____

4) Do you have (Have you had) any buttock, hip, leg, knee, ankle, or foot injuries or strains?
   Explain:_____

5) Do you have (Have you had) any heart or vascular problems?
   Explain:_____

6) Have you ever been through cardiovascular rehabilitation?
   Explain:_____

7) Do you have high blood pressure, cholesterol, or triglycerides?
   Explain:_____

8) Do you have asthma or other bronchial/pulmonary/respiratory conditions?
   Explain:_____

9) Do you have (Have you had) any kidney problems?
   Explain:_____

10) Are you diabetic or hypoglycemic?
    Explain:_____

11) Have you had any surgery within the past two years?
    Explain:_____

12) Have you ever been through physical therapy before?
    Explain:_____

13) Do you smoke? ☐ YES☐ NO

14) Are you on any medications?
    Please list:_____ _____
    _____ _____
    _____ _____

15) Do you have any conditions not listed?
    Explain:_____

Your signature _____ Date _____

Office Use Only:

Date Given to EP: _____ Date Cleared by EP: _____ Chart Made: _____

Staff Initials: _____

AGREEMENT TO PARTICIPATE
POOL THERAPY AND AQUATICS

I voluntarily agree to participate in Mills Peninsula Health Services aquatic therapy programs. I do so at my own risk. I agree to follow the pool rules and the recommendations of the pool staff. I further agree not to exceed these recommendations; and if I do so it will be at my own risk. No guarantees or assurances have been given to me as to the results of aquatic therapy. I understand that there can be risks involved in pool therapy including, but not limited to, hypotension, dizziness, skin reactions to water, falls, and drowning.

Should any complications occur, I consent to the medical therapy which is required to correct the complication. Emergency equipment and trained personnel are available to manage any problems which may arise. I fully understand the risks and responsibilities of participating in the pool programs.

I also acknowledge that I will not hold the hospital responsible for loss or damage of personal property.

I acknowledge that I have read the consent completely, understand its content fully and have had all my questions answered.

Financial Rules

1. Independent payment is due on the 1st of every month.
2. All bounced Checks will require repayment with an additional bank fee.
3. To Freeze (stop billing) your account due to an absence we require 10 days prior notice.
4. Refunds of any sort will not be granted after 30 days.
5. Credit for the paid month will only be granted if advanced notice is given 5 days *prior* to that month. No credit will be granted if the month has past and you wait to request for credit.
   - Independent- If you pay for 6 or 12 months- failure to use the facilities during the time paid for: No credit will be given unless 5 days prior to that particular month.
   - This may be waived under supervisor's discretion
6. Independent- Should you opt to pay for 6 or 12 months 'Pool closure discount' will already be accounted for in the payment.

Should you have questions regarding you account, please call:
Jennifer Scopazzi, Exercise Physiologist (650) 696-4438

Membership Rules

1. No loud, reckless or abusive behavior will be tolerated.
2. Any member not abiding by the rules and regulations shall have his/her membership terminated and will be required to leave the facility.
3. Members are responsible for providing accurate and updated medical and residential information to the staff.

_____ _____

PARTICIPANT DATE

_____

POOL STAFF MEMBER

_____

PARENT OR GUARDIAN, If applicable

Mills-Peninsula Health Services

100 South San Mateo Drive
San Mateo, CA 94401
650-696-4315

Dear Dr. _____

Your patient, _____, would like to enroll in an aquatics exercise class, independent exercise, or aquatics bodywork (WATSU) in the pool at Mills Health Center.

The temperature of the swimming pool is 88-90°.

Are there any contraindications or restrictions to water exercises?

Yes No

If yes, please explain:

_____

_____

_____

_____

_____ _____

Doctor's signature Date

If you would like to fax this to us, please fax at 650-696-4485. If you have any questions, please call us at 650-696-4315.

Thank you very much.

PLEASE NOTE, THIS IS NOT A PRESCRIPTION FOR PHYSICAL THERAPY.