Aquatic Physical Therapy Assessment Form

Patient Information

name	
Date of Birth	
Phone	
FINITE	
Email	
Address	
Medical History	
Primary Diagnosis	
Timary Diagnosis	
Current Medications	
Allergies	
Precautions/Contraindications	
Aquatic Safety Screening	
Addatio Saloty Solosiming	
Open Wounds	
Incontinence	
History of Seizures	
Heart conditions	
mean conditions	
Other conditions	
Additional Safety Concerns	
Additional earliety consonie	
Francticus I Assessment	
Functional Assessment	
Mobility Level	
WIGDING LOVE	<u>_</u> 1
Pain Level (0-10)	
i alli Level (0-10)	
Patient Goals	

Therapist Notes		
Assessment Findings		
Plan/Recommendations		
Therapist Name		
Date		