Aquatic Physical Therapy Intake Form

Personal Information

Full Name

Date of Birth

Phone Number

Email Address

Address

Emergency Contact Name

Emergency Contact Phone

Medical History

Primary Diagnosis / Reason for Therapy

Referral Physician (if any)

Relevant Medical Conditions (please specify)

Current Medications

Allergies

Prior Surgeries (relevant to therapy)

Do you have any of the following? (check all that apply):

- [ ] Heart Condition
- [ ] High Blood Pressure

☐ Respiratory Issues

☐ Diabetes

☐ Seizures

☐ Open Wounds/Infections

☐ Other

If you checked "Other," please specify:

Aquatic Therapy Considerations

Are you comfortable in water?

Do you require assistance entering/exiting a pool?

Swimming ability

Use of assistive devices (please specify, if any)

Explain any limitations in movement or balance

Goals for Aquatic Physical Therapy

Additional Comments

Anything else we should know?