## **Aquatic Physical Therapy Intake Form**

## **Personal Information**

Full Name
Date of Birth
Phone Number
There is a second of the secon
Final Address
Email Address
Address
Emergency Contact Name
Emergency Contact Phone
Medical History
Primary Diagnosis / Reason for Therapy
Filliary Diagnosis / Neason for Therapy
Referral Physician (if any)
Polovent Medical Conditions (places enecify)
Relevant Medical Conditions (please specify)
Current Medications
Current Wedications
Allergies
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Prior Surgeries (relevant to therapy)
The cargained (caratamental actor)
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?
<u></u>
Do you require assistance entering/exiting a pool?
Swimming ability
Use of assistive devices (please specify, if any)
Evaluin any limitations in mayoment or halance
Explain any limitations in movement or balance
Goals for Aquatic Physical Therapy
Additional Comments
Anything else we should know?
Anything else we should know?
Anything else we should know?