

MILLS PENINSULA HEALTH SERVICES

AQUATIC INTAKE FORM

Exercise Class  Independent

Date:	
Name:	Date of Birth:
Address:	City Zip
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

<b>Medicine</b>	<b>Dose</b>	<b>Frequency</b>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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

Your signature \_\_\_\_\_ Date \_\_\_\_\_

# 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 1<sup>st</sup> 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:

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\_\_\_\_\_  
Doctor's signature

\_\_\_\_\_  
Date

Dr's Phone Number \_\_\_\_\_

Dr's Address \_\_\_\_\_

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.***