PATIENT HEALTH HISTORY

Name: ____ DOB: ______________ Today's Date: _________________

Referring Doctor: ________________________ PCP: ____________________ Other Doctors: _____________________

Referring Medical Diagnosis: _____________________Onset of Symptoms ___________________Surgery Date ____________

Treatment Contraindication/Precaution: ☐ none ☐ cardiac ☐ HTN ☐ diabetes ☐ cancer ☐ pregnant

Can you: ☐ swim ☐ float * Are you comfortable in water: ☐ 4 ft ☐ 6 ft * Do you lose balance in water? ☐ No ☐ Yes

Have you experienced any negative effects from: ☐ chlorine ☐ exercising in 88-92 degree water

☐ other____

Subjective Information:

Age__________ Weight__________ Height__________

Vocational Status: ☐ N/A ☐ Employed ☐ Not Employed Last Date of Work?___________________________

☐ Retired ☐ Disability ☐ Student Level? ____

Employer:_____________________________________ Occupation:_______________________________________

Social/Living Situation: ☐ Home ☐ Apartment/Townhouse ☐ Stairs How many?_____________________________

Animals____ Other____

Family Living with You_______________________________ Not Living with You______________________________

Exercise History: ☐ sedentary, ☐ moderate, ☐ extreme,

Do you belong to a gym, pool, performing arts center, team, club? Where?_____________________________________

Doing what? ____ How often?___________________________________

Do you know of any reason why you should not participate in an exercise program? ☐ No ☐ Yes

Describe____

Is your doctor aware of your decision to participate in an exercise program? ☐ No ☐ Yes

Has your doctor told you that you have a heart condition and should only do exercise recommended by a doctor?

Have you exercised in: ☐ shallow water ☐ deep water

Do you feel pain in your chest when you do ☐ physical activity ☐ pins and needles ☐ numbness

In the last month have you had ☐ chest pain at rest ☐ dizziness ☐ loss of consciousness

Previous Medical History:

Medications: (all) ____

Smoke_________/day, Years_____, Quit_______ Weight: ☐ Gain ☐ Loss Amount______Why?_______________

Alcohol: ☐ 0-7/week, ☐ 7-14/week, ☐ 14+/week Menses: ☐ N/A ☐ Regular ☐ Irregular Describe ______________

☐ heart_____________ ☐ blood pressure____________ ☐ lung________ ☐ psych ________________

☐ cancer___________ ☐ diabetes__________ ☐ neuropathy______________ ☐ dizziness____________________

☐ headache_________ ☐ blackouts_________ ☐ anemia_________________ ☐ arthritis ☐ pace maker

☐ cataracts_________ ☐ macular degeneration___________ ☐ glaucoma____________ ☐ glasses/contacts_______

☐ pregnant now________________________ ☐ allergies_______________________________ ☐ central pain syndrome

☐ Other conditions/disorders/illness/surgeries____

____

Do you have any: ☐ bladder or bowel incontinence ☐ open wounds ☐ infection

Current Medical History and Symptoms:

Do you have any of the following symptoms? ☐ pain ☐ spasm ☐ tingling ☐ numbness ☐ weakness

☐ swelling ☐ pop/lock/give way ☐ cramps ☐ other____

Where?____

How severe? ☐ constant ☐ Intermittent ☐ _____/10 at present ☐ _____/10 to _____/10 over the last week

Made worse by____ made better by____________________________

Started on _____________ Getting ☐ better ☐ worse ☐ same

Caused by ☐ insidious ☐ MVA ☐ work injury ☐ other____

Dr diagnosed as ___________________Tests: ☐ Xray ☐ MRI ☐ other__________________________________

Treatment to date____________________