

aquaFit Health Check

Surname: _____
Given Name: _____

Gender: _____
Date of Birth: _____

Type of Arthritis: _____

Joints Affected: (please circle)

- Feet
- Ankles
- Knees
- Hips
- Lumbar Spine
- Cervical Spine
- Shoulders
- Elbow
- Wrists
- Fingers

Medical History

Does your patient have any of the following: (please tick appropriate & state nature of condition)

- Abnormal Blood Pressure _____
- Respiratory Conditions _____
- Incontinence B/B _____
- Epilepsy _____
- Joint Replacements _____
- Mild Stroke/ Parkinson's disease/ Multiple Sclerosis _____
- Recent surgery (past 12/12) _____
- Pregnancy – special clearance form required _____
- Cardiac Problems _____
- Diabetes _____
- Recurrent Middle Ear Infection _____
- Skin Conditions/ Open wounds _____
- Kidney Disease _____
- Tinea/ Verrucae Contraindicated _____
- Open wounds Contraindicated _____
- Other _____

Are the above conditions medically controlled? Yes/ No

If no, which conditions are not medically controlled? _____

Could any of the above conditions preclude your patient from taking part in an exercise class?
Yes/ No

If yes, please state which disorder(s) you feel may prevent your patient from attending class?

Is there any medication that your patient MUST bring to the poolside with them? Yes/NO

If yes, please state which medication(s) _____

Can the patient swim? Yes/No

Can the patient participate in the program without assistance of a carer? Yes/No

Doctors name: _____

Doctors Address: _____

Postcode: _____

Phone number(s): _____

Doctors signature: _____ Date: _____

I agree that _____ (name of patient) is fit and suitable to
attend Water Exercise Classes at _____
Conducted by Cassie McQuillan