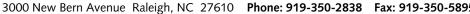
Healthpark Aquatics/Outpatient Rehab Services Health History Screening Questionnaire 3000 New Bern Avenue Raleigh, NC 27610 Phone: 919-350-2838 Fax: 919-350-5895





| Today's Date: | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| Name: | _ □ Male □ Female Age: | Date of Birth: | | | | | | | |
| Home Address: | City/State: | Zip Code: | | | | | | | |
| Home/Cell Phone: | Work Phone: | Work Phone: | | | | | | | |
| Employer/Dept: | Em | Email Address: | | | | | | | |
| Emergency Contact Name: | Emergency Contact | Emergency Contact Phone: | | | | | | | |
| In consideration of being allowed to participate in the activand to use its facilities and equipment in addition to the pay 1. Understand and am aware that strength, flexibility, aerobactivities. I also understand that aquatic activities involve activities and using equipment with knowledge of the day | yment of any fee or charge, I hereby: bic and aquatic exercise, including the us a risk of injury and even death and that | se of equipment, are potentially hazardous t I am voluntarily participating in these | | | | | | | |
| injury or death | ther declare that I have not withheld informillers that would interfere with my safuse of equipment except as hereinafter songes in my health history status and undon my health status may result in revocaticiated with my participation in the activitials information, misinformation or incomparts. | formation regarding my physical soundness fe and healthy participation in any of the stated. I understand that I have a continuing lerstand that misinformation; false statements ion of this application and/or participation ties and services offered by the WakeMed | | | | | | | |
| Acknowledge that I have been informed that a physician's approval is required for my participation in an aquatic exercise / fitness activity or program. I also am informed that this Health History form is to be updated every two years with continued participation in order for me to continue participating in any aquatics program. I agree to update my Health History before the expiration date or will not be allowed to participate until form is complete and signed by my physician. I do hereby assume all responsibility and risk for my participation and activities, and utilization of equipment in my activities, regardless of what I am doing at the time of injury or damage. (Initial) | | | | | | | | | |
| Acknowledge that I have been given a copy of the aquatic facility's rules and code of conduct and agree to follow said rules. My continued participation is contingent on my following and abiding by stated rules (Initial) | | | | | | | | | |
| 5. Acknowledge that the temperature in the pool area is verified the body. I agree to drink plenty of water before coming schedule for my prescription medications and not skip any and not skip any meals before coming to the pool. I will produced to the pool of the pool of the pool of the pool. [Initial] | to participate and drink plenty of water by medications before coming to the poo particularly pay special attention to meal | r after my session. I also agree to maintain my ol. I also agree to eat at my regular meal times I times and consumption of fluids if I am | | | | | | | |
| Member Signature: | Member Printed Name: | Date: | | | | | | | |
| Staff Signature: | Date: | | | | | | | | |
| Staff Use Only: Independent Aquatic Exercise: Post-aquatic therapy progr Therapeutic Aquatics Classes: Group aquatics classes of v therapeutic need. Physical Therapist: Aquatics Classes | | with documented PHYSICIAN APPROVED Assigned Level: 1 2 2+ | | | | | | | |

AQUATICS

Health History Screening Questionnaire



| Naı | me: | | | Birth | date: | Phone Number: | | | |
|--|---|------------------------|---------------------------------------|---|---|---|--|--|--|
| Hei | ght: Weight: | Age: | | | | | | | |
| Physician | | Physician Practice: | | | Physician Phone Number: | | | | |
| 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. | Are you age 40 or older? Do you smoke ten or more cigarettes per day? Do you have a family history of cardiovascular disease prior to age 55 in parents or siblings? (Heart disease, heart event, stroke) Cardiovascular disease (heart disease, stroke), or peripheral vascular disease? Have you had a heart attack? Do you have a heart murmur? Do you experience chest pain? Do you experience skipped heartbeats or a very rapid resting heart rate? Has a doctor ever told you that you have high blood pressure? Has a doctor ever told you that you have high cholesterol (greater than or equal to 240)? Do you experience discomfort in breathing whi lying down or wake up suddenly gasping for air? Chronic lung condition? (Circle type) (Chronic bronchitis, asthma, COPD Do you lose consciousness/experience dizziness? Do you experience seizures? Do you have any other symptoms during exercis or activities? Do you have any weakness or side effects or fati due to a stroke, multiple sclerosis, lupus or other condition? Are you currently pregnant? | Yes | No No No No No No No No | 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. | Do you have diabet Metabolic disease (I Do you have a curre If "yes", please exp Osteopenia and/or Have you been hosystatus changed in the Please specify: Have you had surge Please specify: Do you currently had have you ever had orthopedic problem Are you currently ur specific medical con History of abdomina Arthritis? If "yes", vo Do you have a history of a recent fall? Do you experience of Are you comfortable dications: | c (uncontrollable bladder/bowel)? es? kidney, liver, thyroid)? ent or ongoing orthopedic problem? lain: Osteoporosis (brittle bones)? oitalized or has your medical ne past 6 months? ery within the past 6 months? | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No | | |
| Yo | YSICIAN RECOMMENDATION ur patient is interested in participating interested in participating interest information that may pose possible I CONFIRM the above med | contraindicat | tions to | his/he | er safe participation | on. | | | |
| Printed Physician Name Physician | | | an Signature | | | e | | | |
| | I DO NOT APPROVE the indicated p | orogram. | | | | | | | |
| Printed Physician Name Physician Signa | | | nature | | Date | | | | |
| 0 | ther recommendations/comments/concerns | · | | , | | | | | |