Healthpark Aquatics/Outpatient Rehab Services
Health History Screening Questionnaire

3000 New Bern Avenue Raleigh, NC 27610 **Phone: 919-350-2838 Fax: 919-350-5895**

WakeMed

Today's Date: _____

Name: _____ ☐ Male ☐ Female Age: _____ Date of Birth: _____

Home Address: _____ City/State: _____ Zip Code: _____

Home/Cell Phone: _____ Work Phone: _____

Employer/Dept: _____ Email Address: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Agreement and Release of Liability

In consideration of being allowed to participate in the activities and programs of the WakeMed aquatic facility, WakeMed Health and Hospitals and to use its facilities and equipment in addition to the payment of any fee or charge, I hereby:

1. Understand and am aware that strength, flexibility, aerobic and aquatic exercise, including the use of equipment, are potentially hazardous activities. I also understand that aquatic activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risk of injury or death.
   _____ (Initial)

2. Agree that the answers and statements provided on this health history and screening questionnaire have been answered completely and accurately, to the best of my knowledge. I do hereby further declare that I have not withheld information regarding my physical soundness and any condition, impairment, disease, infirmity or other illness that would interfere with my safe and healthy participation in any of the activities and programs at WakeMed aquatic facilties or use of equipment except as hereinafter stated. I understand that I have a continuing obligation to keep the aquatic staff informed of any changes in my health history status and understand that misinformation; false statements or failure to keep the aquatic staff informed of changes in my health status may result in revocation of this application and/or participation resulting herefrom. Further, I hereby assume all risk associated with my participation in the activities and services offered by the WakeMed aquatics facility and in particular that resulting from any false information, misinformation or incomplete information that might be supplied regarding my safe and healthy participation in said activities and services.
   _____ (Initial)

3. 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)

4. 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 very warm. Warm temperatures along with warm water have a dehydrating effect on the body. I agree to drink plenty of water before coming to participate and drink plenty of water after my session. I also agree to maintain my schedule for my prescription medications and not skip any medications before coming to the pool. I also agree to eat at my regular meal times and not skip any meals before coming to the pool. I will particularly pay special attention to meal times and consumption of fluids if I am diabetic or pre-diabetic. I agree to relay to my therapist or instructor any negative health issues from prior aquatic exercise sessions or otherwise, prior to and before entering the pool.
   _____ (Initial)

Member Signature: _____ Member Printed Name: _____ Date: _____

Staff Signature: _____ Date: _____

Staff Use Only:

_____ **Independent Aquatic Exercise:** Post-aquatic therapy program. Participants work independently.

_____ **Therapeutic Aquatics Classes:** Group aquatics classes of varying intensity/ability levels for individuals with documented **PHYSICIAN APPROVED** therapeutic need.

Physical Therapist: _____ **Aquatics/Fitness Specialist:** _____ **Assigned Level: 1 2 2+**

AQUATICS
Health History Screening Questionnaire

WakeMed

Name: _____ Birthdate: _____ Phone Number: _____

Height: _____ Weight: _____ Age: _____

Physician Name: _____ Physician Practice: _____ Physician Phone Number: _____

1. Are you age 40 or older? ☐ Yes ☐ No
2. Do you smoke ten or more cigarettes per day? ☐ Yes ☐ No
3. Do you have a family history of cardiovascular disease prior to age 55 in parents or siblings? (Heart disease, heart event, stroke) ☐ Yes ☐ No
4. Cardiovascular disease (heart disease, stroke), or peripheral vascular disease? ☐ Yes ☐ No
5. Have you had a heart attack? ☐ Yes ☐ No
6. Do you have a heart murmur? ☐ Yes ☐ No
7. Do you experience chest pain? ☐ Yes ☐ No
8. Do you experience skipped heartbeats or a very rapid resting heart rate? ☐ Yes ☐ No
9. Has a doctor ever told you that you have high blood pressure? ☐ Yes ☐ No
10. Has a doctor ever told you that you have high cholesterol (greater than or equal to 240)? ☐ Yes ☐ No
11. Do you experience discomfort in breathing while lying down or wake up suddenly gasping for air? ☐ Yes ☐ No
12. Chronic lung condition? ☐ Yes ☐ No
    (Circle type) (Chronic bronchitis, asthma, COPD)
13. Do you lose consciousness/experience dizziness? ☐ Yes ☐ No
14. Do you experience seizures? ☐ Yes ☐ No
15. Do you have any other symptoms during exercise or activities? ☐ Yes ☐ No
16. Do you have any weakness or side effects or fatigue due to a stroke, multiple sclerosis, lupus or other condition? ☐ Yes ☐ No
17. Are you currently pregnant ? ☐ Yes ☐ No
18. Are you incontinent (uncontrollable bladder/bowel)? ☐ Yes ☐ No
19. Do you have diabetes? ☐ Yes ☐ No
20. Metabolic disease (kidney, liver, thyroid)? ☐ Yes ☐ No
21. Do you have a current or ongoing orthopedic problem? ☐ Yes ☐ No
    If "yes", please explain: ☐ Yes ☐ No
    _____
    _____
    _____
22. Osteopenia and/or Osteoporosis (brittle bones)? ☐ Yes ☐ No
23. Have you been hospitalized or has your medical status changed in the past 6 months? ☐ Yes ☐ No
    Please specify: _____
24. Have you had surgery within the past 6 months? ☐ Yes ☐ No
    Please specify: _____
25. Do you currently have a hernia? ☐ Yes ☐ No
26. Have you ever had any orthopedic surgery or orthopedic problems? Please specify: ☐ Yes ☐ No
    _____
    _____
27. Are you currently under the care of a doctor for a specific medical condition? Please specify: ☐ Yes ☐ No
    _____
    _____
28. History of abdominal surgery or hernia repair? ☐ Yes ☐ No
29. Arthritis? If "yes", where? _____
30. Do you have a history of falls or have you experienced a recent fall? ☐ Yes ☐ No
31. Do you experience difficulty with balance? ☐ Yes ☐ No
32. Are you comfortable in chest deep water? ☐ Yes ☐ No

Explain any current/past complications or conditions:

_____
_____
_____
_____

Medications:

Type	***Frequency***	***Dosage***

PHYSICIAN RECOMMENDATION

Your patient is interested in participating in the WakeMed aquatic fitness program and has provided us with required health history information that may pose possible contraindications to his/her safe participation.

☐ **I CONFIRM** the above medical conditions and **clear** this individual to participate in aquatic therapy.

Printed Physician Name **Physician Signature** **Date**

☐ **I DO NOT APPROVE** the indicated program.

Printed Physician Name **Physician Signature** **Date**

Other recommendations/comments/concerns: _____
_____