Aquatic Rehab & Wellness Center

P.O. Box 3681
Lake Havasu City, AZ 86405
(928) 680-8229 Jessica@arawc.com

Patient Information:

Last Name: _____ First Name: _____ M.I._____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____ Birth Date: _____ / _____ /_____

Email Address: _____ Sex: ☒ Male ☒ Female

Parent/Guardian (if applicable): _____

Care Provider Information:

Referring Practitioner: _____ Phone: (_____)
_____ - _____

Primary Care Provider: _____ Phone: (_____) _____ - _____

In Case of an Emergency:

Name of Local Friend or Relative:
_____

Relationship to Patient: _____ Best Contact Phone #: (_____) _____ -
_____

	Yes	No
Can you swim well enough to save your own life?	☐	☐
Are you afraid of the water?	☐	☐
Have you been through aquatic physical therapy before?	☐	☐
Would you be interested in participating in future research?	☐	☐

(You will be provided more information if you qualify and all personal information will be confidential)

_____
Printed Name of Patient

_____ _____

Patient / Guardian Signature **Date**

MEDICAL HISTORY FORM

General	Yes	No
Hypertension or low blood pressure	☐	☐
Fatigue	☐	☐
Nervousness/Irritability/Depression	☐	☐
Heart Condition	☐	☐
Contagious Disease	☐	☐
Areas of Pain	**Yes**	**No**
Neck/Head	☐	☐
Mid-Back/Scapulae	☐	☐
Low Back/Pelvis/Sciatica	☐	☐
Shoulders/Elbow/Wrists/Hand/Finger	☐	☐
Hip/Thigh/Knee/Lower leg/Ankle/Foot	☐	☐
Chest/Ribs/Breastbone	☐	☐
Muscle Conditions	**Yes**	**No**
☐		
Muscle Spasm	☐	☐
Pins & Needles Sensation	☐	☐
Numbness	☐	☐
Pinched Nerve- Where? _____	☐	☐
"Slipped disk"- Where? _____	☐	☐
Loss of Balance/ Difficulty Walking	☐	☐
Lungs	**Yes**	**No**
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

	Yes	No
Severe Sprain/Strains	☐	☐
Dislocation/Fracture	☐	☐
Tendonitis/Bursitis	☐	☐
Swollen Joints	☐	☐
Limited Weight Bearing	☐	☐
Stroke/CVA	☐	☐
Fainting/Lightheadedness	☐	☐
Arthritis (type) _____	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes/Hypoglycemia	☐	
Hearing Loss/Hearing Aids	☐	☐
Poor Eyesight/Contacts	☐	☐
Tracheotomy	☐	☐
Open lesions/wounds	☐	☐
Swallowing Difficulties	☐	☐
Bowel/Bladder Control Issues	☐	☐
Urinary Tract Infection	☐	☐
Overweight (20 lbs or more)	☐	☐
Undergoing radiation	☐	☐
Cancer (type) _____	☐	☐

Habits

☐ Alcohol Drinks Per Week _____
☐ Coffee/Soda Cups a Week _____
☐ 3-4 x week

Work Activity

☐ Smoking Packs a Day
☐ Low
☐ Standing
☐ Light Labor
☐ Heavy Labor

Stress Level

_____
☐ None
☐ Medium
☐ High

Exercise

☐ Sitting
☐ 1-2 x week
☐ 5+ x week

What types of exercise do you perform? _____

What things cause stress in your life? _____

Are you taking any seizure medications? ☐ No ☐ Yes, if yes, please list name:

_____

Please list, or attach a list of, **ALL medications you are currently taking** including over the counter medications and herbals: _____

_____

List all surgeries you have had in past years, including the dates: _____

_____

Are you pregnant? ☒ No ☒ Yes If yes, what week: _____

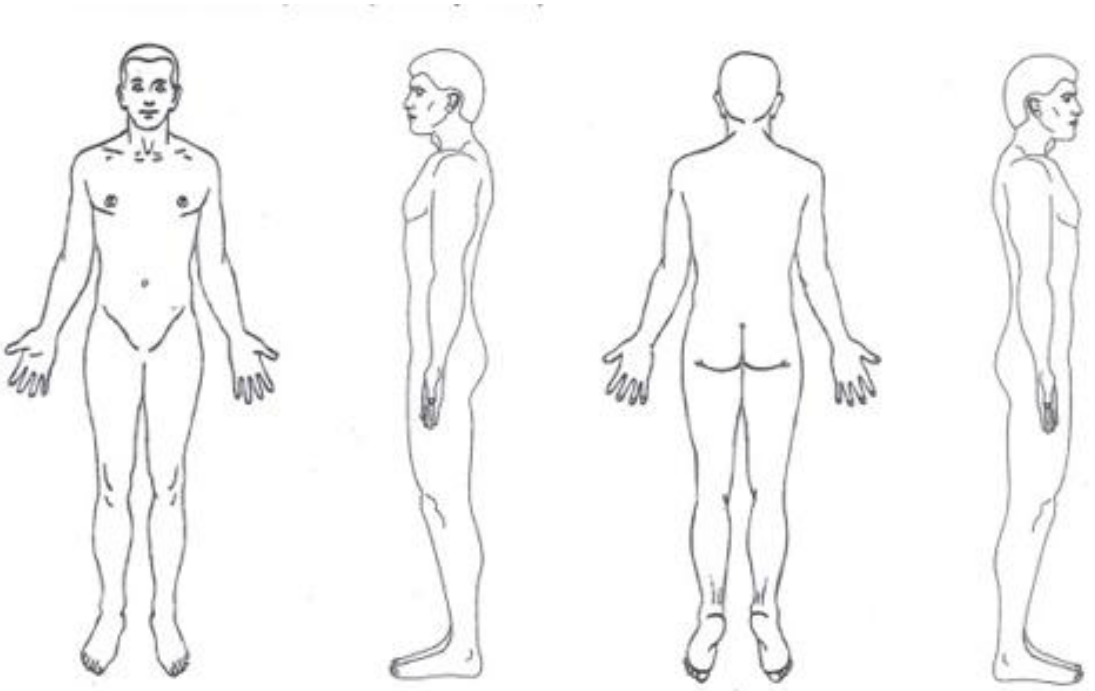
Have you previously had treatment for the condition you are being seen for today? If yes, please describe.

PAIN HISTORY & SUBJECTIVE ASSESSMENT:

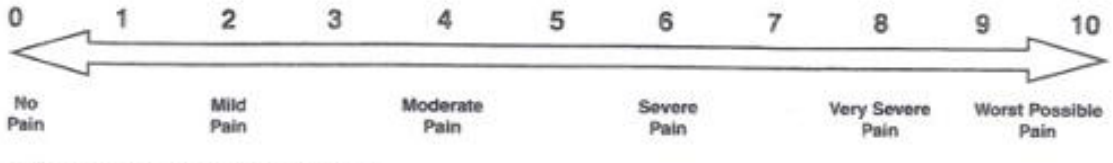
///: Aching ×: Burning

Δ: Stabbing ⬇: Numbness/tingling

1. Please mark the areas of your body where you feel pain.



2. Please indicate the intensity of each area of pain with a number that corresponds to the scale below:



3. Please answer the following questions:

When did you first start experiencing the symptoms for what you are being seen for today? _____

	Yes	**No**	**Please Describe**
Are you in pain today?	☒	☐	

Is the pain always there? ☒ ☐ ☐

_____

Does it get worse when you move in certain ways? ☐ ☐ _____

Do other things make it better or worse? ☒ ☐ ☐

_____

What has your pain affected? (check all that apply) ☒ Mobility ☒ Exercise ☒ Sleep ☒ Work ☒ Concentration

Social Activities ☒ Appetite ☒ Relationships ☒ Other: _____

Please describe all **past** treatments for your pain. (May include: medications, treatment, surgeries, etc)

_____

FIBROMYALGIA IMPACT QUESTIONNAIRE

Directions: For questions 1 through 10, please circle the number that best describes how you did overall for the past week. If you do not normally do something that is asked, cross the question out.

Were you able to:	Always	Most	Seldom	Never
1. Do shopping?	0	1	2	3
2. Do laundry?	0	1	2	3
3. Prepare meals?	0	1	2	3
4. Wash dishes by hand?	0	1	2	3
5. Vacuum a rug?	0	1	2	3
6. Make beds?	0	1	2	3
7. Walk several blocks?	0	1	2	3
8. Visit friends or relatives?	0	1	2	3
9. Do yard work?	0	1	2	3
10. Drive a car?	0	1	2	3

Of the 7 days in the past week, how many days did you feel good?

0 1 2 3 4 5 6 7

How many days last week did you miss work because of your Fibromyalgia? If you do not have a job outside the home, leave this item blank.

0 1 2 3 4 5 6 7

Directions: For the remaining items, mark the point on the line that best indicated how you felt overall for the past week.

When you worked, how did the pain or other symptoms of your Fibromyalgia interfere with your ability to do your job?

No problems Great difficulty

/---------/---------/---------/---------/---------/---------/---------/---------/---------/---------/

How bad has your pain been?

No pain Severe pain

/---------/---------/---------/---------/---------/---------/---------/---------/---------/---------/

How tired have you felt?

No tiredness Very tired

/---------/---------/---------/---------/---------/---------/---------/---------/---------/---------/

How have you felt when you get up in the morning?

Awoke well rested Awoke very tired

/---------/---------/---------/---------/---------/---------/---------/---------/---------/---------/

How bad has your stiffness been?

No stiffness Very stiff

/---------/---------/---------/---------/---------/---------/---------/---------/---------/---------/

How nervous or anxious have you felt?

Not anxious Very anxious

/---------/---------/---------/---------/---------/---------/---------/---------/---------/---------/

How depressed or blue have you felt?

Not depressed Very depressed

/---------/---------/---------/---------/---------/---------/---------/---------/---------/---------/