AQUAMOTION
REHABILITATION AND FITNESS

Confidential Patient Information

Date:_____

First Name: _____ Last Name: _____

Birth Date (MM/DD/YY):_____

Home Address: _____

City: _____ Postal Code: _____

Home Tel: _____ Cell: _____

Email: _____

Family Doctor: _____

Phone #: _____

Referring professional and phone #: _____

ICBC Claim #: _____

Emergency Contact: _____

Phone Number: : _____

Confidential Health Information

Main Health Complaint:

Other complaints (Any past hospitalizations, accidents, illness, surgeries?)

Please list any Medications you presently take:

Known Allergies (including medications, foods, seasonal, etc)

Overall Stress Level: □ None □ Low □ Medium □ High

Reasons:

Please Note:

Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all therapies, whether private or insured, is ultimately the responsibility of the patient.

I authorize Aquamotion and all associated rehabilitation and fitness professionals to collect my personal and medical information as documented. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: _____ Date: _____

Please indicate if you believe if any of the following apply to you: (P= past, C= current)

- ☐ Asthma
- ☐ Chronic Fatigue
- ☐ Epilepsy High Blood Pressure
- ☐ Migraines
- ☐ Seizures
- ☐ Arthritis
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Obesity
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Lung conditions
- ☐ Kidney Conditions
- ☐ Thyroid Conditions
- ☐ Osteoporosis
- ☐ Stress
- ☐ Heart Conditions
- ☐ Hernia(s)
- ☐ Other

Current Condition:

Please describe your current condition and symptoms: _____

_____

_____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated: