



**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:

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

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Please list any Medications you presently take:

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

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Overall Stress Level:  None  Low  Medium  High

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Reasons:

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### **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)

- |  |   |
|--|---|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Chronic Fatigue     | <input type="checkbox"/> High Cholesterol   |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Lung conditions    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Conditions  |
| <input type="checkbox"/> Migraines           | <input type="checkbox"/> Thyroid Conditions |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Osteoporosis       |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Stress             |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart Conditions   |
| <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Hernia(s)          |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Other              |
| <input type="checkbox"/> Obesity             |   |

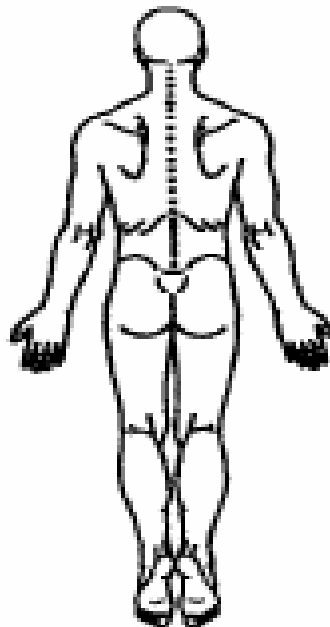
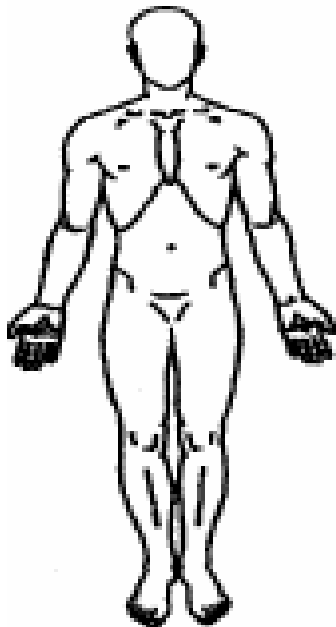
### Current Condition:

Please describe your current condition and symptoms:

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



- |                         |        |
|-------------------------|--------|
| Aching                  | ○ ○    |
| Stabbing                | X X X  |
| Shooting                | → →    |
| Burning                 | # # #  |
| Numbness<br>or Tingling | ... .. |