Health Screening for Pool Therapy Program

Client Name: _____

Home Phone: _____ **Business Phone:** _____

Address: _____

Emergency Contact: _____**Phone:**_____

Health Screening: Please respond to the following questions by checking 'yes' or 'no'.

Date of Birth: Day_____ Month_____ Year_____	√ Yes	√ No
1. Has your doctor ever said that you have a heart condition AND that you should only do physical activity recommended by a doctor?		
2. Do you feel pain in your chest when you do physical activity?		
3. In the past month, have you had chest pain when you were not doing physical activity?		
4. Do you lose your balance because of dizziness or do you ever lose consciousness?		
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or a heart condition?		
7. Are you over age 40 AND inactive?		
8. Are you pregnant now, or have you had a baby in the last 6 weeks?		
9. Do you know of any other reason why you should not do physical activity?		

If you answered 'yes' to one or more of these questions, please consult with your personal physician by phone or in person before becoming more physically active.

Please check any of the following that apply to you.

- ☐ Contagious skin rashes, open wounds
- ☐ Waterborne diseases: typhoid, cholera, dysentery
- ☐ Allergies to chlorine, bromine or other pool chemicals
- ☐ Fever of 38° C or higher
- ☐ Pulmonary disease or insufficiency which will not accommodate the increased work of breathing (vital capacity less than 1500 ml)
- ☐ Unstable angina; cardiac or renal failure
- ☐ Kidney disease where there is an inability to adjust to fluid loss
- ☐ Urinary tract infections / lack of bowel or bladder control
- ☐ Epilepsy, uncontrolled seizures
- ☐ Excessive fear of water
- ☐ Cognitive functional impairment which would pose a risk to the client or others
- ☐ Perforated ear drum
- ☐ Abnormal blood pressure (hyper / hypotensive)
- ☐ Current or recent radiation treatment (less than 3 months)
- ☐ Severely weakened or deconditioned state which would pose a risk for safety
- ☐ Hiatus hernia; acid reflux

If you checked any of these boxes, you should NOT to participate in a pool therapy program at this time without the specific recommendation of your physician.

Show your doctor this form and the questions you answered 'yes' to or the boxes you have checked. Discuss with your physician your suitability to participate in the CBI pool therapy program. Your doctor may fill in the note of permission at the bottom of this form.

I _____,verify that I have answered all questions honestly, that I am able to participate in the CBI pool therapy program and if necessary, have been given medical approval to participate in this program.

Client Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Physician's Notes if required:

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Physician's signature:_____ Date: _____