AQUA EXERCISE FOR INDIVIDUALS WITH MS

Intake Form and Health Screening Questionnaire

Name_____ Today's date (MM/DD/YYYY): _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Preferred phone: _____(home/cell) Alternate phone: _____(home/cell)

Email: _____

Emergency Contact

Name: _____ Relationship: _____

Preferred phone: _____(home/cell) Alternate phone: _____(home/cell)

Physician Info

Primary physician: _____ (_____) _____

Other physicians involved in your treatment/care: (use reverse side if necessary)

Name	Specialty	Phone number
_____	_____	(_____) _____
_____	_____	(_____) _____
_____	_____	(_____) _____

Ho w did you learn about this program?

Medical History – General

Have you ever had any of these health problems?

Pulmonary (lung) problems	☐ Yes	☐ No
Heart problems or surgery	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Altered heart rate	☐ Yes	☐ No
Dizziness or fainting (unrelated to cancer treatment)	☐ Yes	☐ No
Chest, neck or arm pain	☐ Yes	☐ No
Pain or cramping in legs while walking	☐ Yes	☐ No
Short-term weakness on one side of the body	☐ Yes	☐ No
Elevated blood pressure	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Smoker or previous smoker	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No

If the answer is yes to any of the above, please describe briefly:

_____

_____

Other major illnesses (include surgeries/accidents/chronic pain)

_____

_____

_____

Medications/Lifestyle/Other:

List current medications (including vitamins and over-the-counter)

_____

_____

_____

Describe your health at the present time: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List types of exercise you participate in regularly and describe the frequency of your practice

_____

_____

_____

Do you have any physical limitations that restrict your daily living activities or ability to exercise?

☐ No ☐ Yes If yes, please explain

_____

_____

Are you currently working? ☐ Yes ☐ No

What is your level of activity at work? ☐ Completely sedentary ☐ Moderately active ☐ Very active/physical

Describe your past experience with resistance training and aerobic training:

_____

_____

_____

Do you have any concerns about starting this exercise program?

_____

_____

_____

What expectations do you have from this program?

_____

_____

_____

How will you determine your personal success/satisfaction with this program?

_____

For Staff Use/General Notes: T-SHIRT SIZE: S M L XL XXL

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Aquatic Arthritis Foundation Program

PARTICIPANT CONSULTATION AND INTAKE FORM

PARTICIPANT INTAKE FORM

The purpose of this intake form is to understand the needs of participants in the Aquatic Arthritis Foundation program. This form is designed to be filled out and returned prior to the beginning of the program.

Date: _____ Participant ID (filled out by YMCA): _____

Participant Name: _____ Birth Date: _____

Emergency Contact Name: _____

Contact Phone: _____ Contact Email: _____

GOALS

What, if any, specific goals do you have for the participant in the Aquatic Arthritis Foundation Program (check all that apply)?

☐ Physical: strength, endurance, balance, motor skill development (please specify below)

_____

_____

_____

☐ Other (please specify below)

_____

Has the particpant been involved in aquatic programs at another YMCA or through another organization?

☐ Yes

☐ No

If yes, what organization and what type of program?

_____

Is the particpant fearful of the water? The pool program will be held in the 4ft section of the pool.

☐ Yes

☐ No

AREAS OF SUPPORT

Medical Needs

Does the participant have any medical or physical restrictions?

_____

Are there any medical concerns we should be aware of?

_____

How will the particpant enter the pool?

☐ Independently using the steps

☐ With assistance from another person/ chairlift

Does the particpant have difficulty with any of the following (check all that apply)? **Physical**

☐ Gait ☐ Balance ☐ Coordination ☐ Strength ☐ Endurance

☐ Range of motion

Check how the participant identifies in the following areas (check all that apply): **Vision**

☐ No significant vision impairment ☐ Can see light/shadows ☐ Legally blind

Hearing

☐ No significant hearing impairment ☐ Mild loss ☐ Moderate/severe loss

☐ Deaf

Speech/Communication

☐ Verbal ☐ Nonverbal ☐ Sign language

Will the particpant use exercise/instructional equipment (pool noodle, float belt, barbells, etc.)?

☐ Yes

☐ No

☐ Unsure

Additional comments: