Charlie Finlay-Jones
PRINCIPAL PHYSIOTHERAPIST
[illegible]
Provider No. [illegible]
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Jason Carswell
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APA
MEMBER

Aquatic Fitness Pre-Exercise Screening

Patient Details

Title: Surname: First Name:

Address: Postcode:

Phone: (Mob) Home:

Date of Birth: Emergency Contact:

Family GP: Pension/Concession No:

It is your responsibility to answer our health screening questions honestly and to provide any information to our staff that could effect your ability to exercise safely in our facility.

You are advised, that should you suffer from any of the following health conditions, you will be asked to provide a Doctor's Certificate of Physical Capacity before commencing any exercise program at Newcastle Aquatic Physiotherapy. Have you now or in the past suffered from the following:

Any Heart conditions e.g Angina, Heart Attack, CABG, Heart Valve or Artery Disease?
Yes No

Have you had a stroke or TIA (mini stroke)? Yes No

Do you suffer from any respiratory conditions and/or shortness of breath on exertion?
Yes No

Do you ever experience any unexplained chest pains, dizziness, loss of balance or faintness? Yes No

Do you have any other condition that may hinder your ability to exercise e.g acute/chronic injuries, pregnancy, epilepsy, organ transplants or cancer?
Yes No

I believe that to the best of my knowledge, all of the information I have supplied within this screening tool is correct. I understand that I undertake this exercise at my own risk and will seek to provide medical approval for any of the above conditions.

Client Signature: **Date:**

Please do not attend if you are unwell or have any flu like symptoms.

Aquatic Fitness Class Health Clearance Check

Question	Yes	No	Comment
1. Are you water confident?			
2. Do you have/have you ever had asthma?			
3. Have you had radiotherapy or chemotherapy in the last 6 weeks			
4. Do you wear contact lenses or hearing aides?			
5. Do you have any contagious diseases?			
6. Do you have skin infections e.g. tinea, cellulitis, rashes			
7. Do you have/have you ever had a DVT? (venous clots)			
8. Do you have Type 1 or Type 2 Diabetes?			
9. Do you suffer from episodes of epilepsy?			
10. Do you have haemophilia? (bleeding disorder)			
11. Do you have Hepatitis B, C or HIV?			
12. Are you continent? Both bowel & bladder?			
13. Do you have any kidney disease?			
14. Do you have any open wounds or sores?			
15. Do you have any thyroid problems?			
16. Have you ever had a pulmonary embolism? (clot in the lung)			
17. Do you have blood pressure problems?			
18. Do you suffer from vertigo? (dizziness)			
19. Do you wear pain patches?			
20. Do you suffer from any other conditions not mentioned above?			