AQUASTRETCH™

Health Screening Questionnaire for AquaStretch™ & Aquatic Exercise Participation

Full Name (Print in ink please):_____

Address: _____

Email: _____ **Phone:** _____

Date of Birth: _____

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

	√ Yes	√ No
1. Has your doctor ever said that you have a heart, liver, or other condition that could be made worse by gentle activity in warm water?		
2. Do you have any open wounds or skin that is irritated by pool water?		
3. Are you afraid of water or water phobic?		
4. Are you taking blood thinners?		
5. Do you lose your balance because of dizziness or do you ever lose consciousness?		
6. Do you have a bone or joint problem that could be made worse by movement?		
7. Are you taking prescription drugs for blood pressure, a heart condition or epilepsy?		
8. Do you suffer from chronic pain or have you been diagnosed with Fibromyalgia (FMS)?		
9. Are you pregnant now, or have you had a baby in the last 6 weeks?		
10. Have you been diagnosed with osteopenia or osteoporosis?		
11. Have you had a recent surgery or injury to your bones, muscles, organs or skin?		
12. Are you incontinent?		
13. Do you have a hypermobility syndrome such as Marfan's Syndrome?		
14. Do you have COPD or difficulty breathing when standing in chest deep water?		
15. Do you know of any other reason why you should not participate in AquaStretch™?		

If you answered 'yes' to one or more of these questions, please consult with your personal physician by phone or in person before participating in Self-AquaStretch. Tell your doctor about the questions you answered 'yes' to, and discuss your suitability to participate.

If you have answered 'yes' to a question, and have already been seen by your MD, and told you could participate in activity, please place your initials beside the item marked 'yes', and write: "MD OKd".

I verify that I have answered the health screening questions honestly, that I have no health restrictions preventing me from participating in AquaStretch™ and therapeutic aquatic exercise. If I have answered 'yes' to any questions, I verify that I have been given medical approval to participate or have discussed my suitability to participate with my AquaStretch™ Facilitator.

Signature:_____ **Date:**_____

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Informed Consent & Liability Waiver

Print Your Name: _____ Phone: _____

Date of Birth: _____ / _____ / _____

Day Month Year

Informed Consent: I, _____acknowledge that there is the risk of injury or death associated with participating in any physical activity including AquaStretch™ and therapeutic aquatic exercise.

I assume all such risks. I release Connie Jasinskas, colleagues working under her guidance, and the facility in which we interact, from any liability for damages or claims arising out of injury sustained by myself during or after participating in AquaStretch™ or therapeutic aquatic exercise, whether or not unintentional negligence occurred.

Please initial beside each box below to indicate your agreement with each statement:

☐ I understand and am aware that AquaStretch™, including the use of equipment, entry and exit from the pool and change room involves a potential risk of injury, and that I am voluntarily participating in these activities at my own risk.

☐ **I agree that if I feel light headed, dizzy, nauseous, or experience pain or discomfort at any time during these activities, I will immediately stop the activity, and inform the Facilitator.**

☐ I agree to inform the Facilitator working with me at any time while participating in AquaStretch™, or performing therapeutic aquatic exercise, of any health conditions that might affect my participation.

☐ **I understand that I am not obliged to participate in any activity prescribed by anyone working with me in the pool or otherwise, unless I wish to do so. I know that I have the right at any time to decline or stop participation in AquaStretch™ or therapeutic aquatic exercise.**

Signature:_____ Date:_____

Witness' Signature:_____ Date:_____

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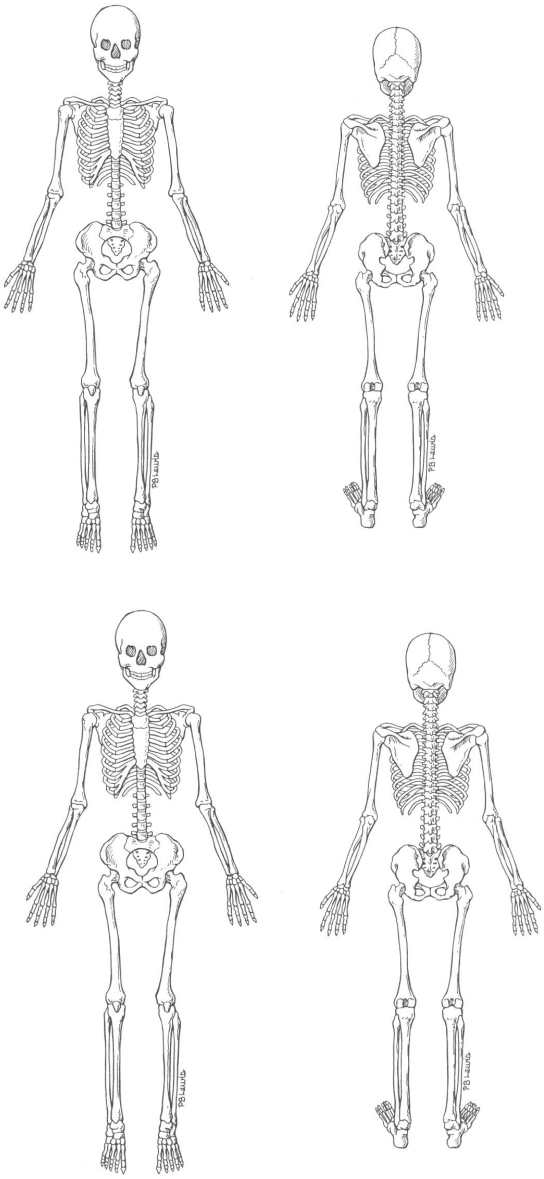
AquaStretch™ – Client Self-Evaluation Form Date: _____

Name: _____ Phone:_____

What is the primary purpose of today's AquaStretch™ session? _____

_____

Before AquaStretch™ Sessio



Immediately After AquaStretch™

Please use this form to rate your pain today before and immediately after your session.

STEP 1:
On the diagrams (left), **circle** the specific body area(s) that hurt, or feel painful with movement.

STEP 2:

Place a number beside each circle:

0 Pain free

1 Pain is hardly noticeable

2 Pain is minor annoyance, comes & goes

3 Pain is somewhat distracting

4 Pain is quite distracting

5 Pain cannot be ignored for more than a few minutes at a time

6 Pain is always there (may still do daily activities)

7 Pain is always there (difficult to concentrate, interferes with sleep; you can still function with effort)

8 Pain severely limits physical activity. Nausea and dizziness may result from pain.

9 Pain makes you unable to speak.

10 Pain makes you pass out. Intolerable.

Additional Comments (if desired): _____

_____

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Health Issues Affecting AquaStretch™ Participation

The health issues listed below relate to being in pools, as well as AquaStretch™ Procedures.
Clients with health risks should be medically screened before participating in AquaStretch™.
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 yourself or others
- ☐ Perforated ear drum
- ☐ Uncontrolled 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
- ☐ Soft Tissue Tears
- ☐ Abnormal laxity of joints
- ☐ Breaks (fractures)
- ☐ ≤ 6 weeks post-operative
- ☐ Long-term steroid use
- ☐ Edema of unknown cause (should get medical clearance first)
- ☐ Heavy meds or substance abuse
- ☐ Involved in litigation re: your injury
- ☐ Joint replacement
- ☐ Osteoporosis
- ☐ Anticoagulant medications (possible bruising)
- ☐ Instability of the first vertebrae below the skull (atlas, axis).
- ☐ Whiplash (do not do AS within first 2 weeks of injury)
- ☐ Cervical fusion (bones of the neck have been surgically fused).
- ☐ Vertebral artery compromise:
  - *Drop attacks (loss of motor control = collapse)*
  - *Lip paraesthesia (funny sensation = numbness, tingling, burning…)*
  - *Nystagmus (rapid, uncontrolled flicking of eyes side to side)*
  - *Spinal cord compression/ compromise (ie: stenosus)*
  - *Multiple symptoms in the extremities*
- ☐ Signs of nerve root compression:
  - *Pain, numbness and tingling distally (toward hands / feet)*
  - *Loss of sensation*
  - *Isolated muscle weakness*