

## AQUATIC PHYSIOTHERAPY ASSESSMENT FORM



AUSTRALASIAN PHYSIOTHERAPY ASSOCIATION

Date-----

SURNAME----- Given Names-----

Address-----

-----Postcode-----

Hm Ph----- Wk Ph/Mob----- Email/fax -----

DOB:----- Occupation -----

Doctor (GP) ----- Address/Ph. -----

-----Specialist -----

Other Physiotherapist ----- Ph. -----

Next of kin-----Contact details:-----

Social Situation: Live alone ☐ Family Support ☐ Stairs in house ☐ Other comments: -----

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Referred by: please circle one of the following    **Friend**    **Self**    **Doctor**    **Physio**    **Other**

### **PAYMENT DETAILS**

Will this injury be subject to an insurance claim or legal action?    Yes ☐    No ☐

#### **Private patient**

Are you a pensioner or on a health care card?-----

Do you have Private Health Insurance for Physiotherapy?-----Fund-----

#### **Payment by another body**

**DVA**    Gold Card ☐ or White Card ☐    DVA No:-----

DVA-D904 date:-----

**EPC**    ☐    date of referral: -----    Drs Prov No:-----

**Workcover/CRS/Insurance** claim/Other (please state)-----

Claim/File No:-----Contact person-----

Address-----

Ph-----Fax-----Date of accident/injury-----

Workcover-Medical Certificate date:-----

## CHECKLIST FOR PRECAUTIONS AND CONTRAINDICATIONS

Yes No

- ☐ ☐ Heart condition (angina, medication) -----  
☐ ☐ Uncontrolled blood pressure (high or low)-----  
☐ ☐ Epilepsy (frequency of fits)-----  
☐ ☐ Diabetes-----  
☐ ☐ Swallowing problems-----  
☐ ☐ Respiratory conditions (shortness of breath, asthma)-----  
☐ ☐ Peripheral Vascular Disease-----  
☐ ☐ Integrity of skin (broken, ulcers, dressings)-----  
☐ ☐ Skin condition (tinea, plantar warts, allergies)-----  
☐ ☐ Recurrent ear infections or grommets-----  
☐ ☐ Visual impairment-----  
☐ ☐ Hearing difficulties (aids)-----  
☐ ☐ Acute inflammatory condition (Rheumatoid Arthritis)-----  
☐ ☐ Cancer (Radiotherapy/Chemotherapy?)-----  
☐ ☐ Genito-urinary tract (infections, incontinence, catheter)-----  
☐ ☐ Bowel problems (faecal incontinence, colostomy, recent diarrhoea)-----  
☐ ☐ Pregnant-----  
☐ ☐ Previous surgery-----  
☐ ☐ Haemophilia-----  
☐ ☐ Contagious diseases (measles, flu)-----  
☐ ☐ Contagious diseases Hepatitis, Aids)-----If yes, no pool entry if menstruating  
☐ ☐ Family History of any of above-----

Medications: (reason for each)-----

Swimming Ability: ☐ Good ☐ Moderate ☐ Poor Afraid of the water? ☐ Yes ☐ No

Staff Use Only

Pool rules/ safety explained ☐ Fees explained ☐ Patient told to drink ☐ Fatigue explained ☐

Staff signature----- Date-----

I have to the best of my knowledge given an accurate representation of my medical condition, swimming ability and water safety and agree to advise my physiotherapist if any of the above circumstances change in any way. This is essential as this may change the precautions required or make entry to the pool inappropriate at times. I also accept that there are certain risks involved in any therapeutic activity in water. I have been advised of pool rules and safety guidelines and am aware of factors relating to fatigue and dehydration.

Patient's/Carer's Signature----- Date-----

### Disclaimer:

These aquatic physiotherapy screening forms have been provided as a guide for physiotherapist to use when screening patients before accepting them for aquatic physiotherapy treatment due to the physiology of immersion particularly to the cardiovascular implications, infection control, water safety, current and past medical history. For further details on the responsibilities of the physiotherapist please refer to the 2002 APA Guidelines for Physiotherapists working in and/or managing Hydrotherapy Pools under the sections Clinical Management (assessment, reassessment, documentation) and the Appendices related to screening and infection control.

The screening forms are an adjunct to a full subjective and objective assessment which will be unique to each client. The screening forms can be modified by the treating physiotherapist as necessary for their individual client groups or for individual clients.