Aquatic Orientation

Date/Time: ____________ Swim Instructor: ___________________

Personal Information:
Last Name: _________________________ First Name: _______________________
Phone: (Eve) _________________(Day)_______________Email: __________________________________
Gender (check one): Male ☐ Female ☐ Age: _____
Occupation: ______________________________________

Goal Setting:
Tell us more about your goals (please check all that apply):
☐ Basic Skills ☐ Stroke Refinement ☐ Endurance ☐Strength/Speed Training
☐ Competitive Swimming ☐ Open Water Swimming ☐ Triathlon Training
☐ Weight Loss ☐ Rehabilitation ☐ Other: ______________________

Interests:
☐Group Lessons ☐Private Lessons ☐CPR/AED ☐Lifeguard Training
☐Masters Swim ☐Youth Swim Team ☐Group Exercise Classes

What are your best days to workout (check all that apply):
☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.
☐ Early Morning ☐ Mid-morning ☐Noon ☐ Mid-afternoon ☐ Evening

What obstacles have you encountered that might prevent you from accomplishing your goals?
____
____

Exercise History (please answer all questions):
☐ Yes ☐ No 1. Has your doctor ever said you have heart trouble?
☐ Yes ☐ No 2. Do you frequently have pains in your heart or chest?
☐ Yes ☐ No 3. Do you often feel faint or have spells of dizziness?
☐ Yes ☐ No 4. Has a doctor ever said your blood pressure was too high?
☐ Yes ☐ No 5. Has your doctor ever told you that you have a bone or joint problems such as arthritis, which has been aggravated by exercise or might be made worse with exercise?
☐ Yes ☐ No 6. Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?
☐ Yes ☐ No 7. Are you over the age 65 and not accustomed to vigorous exercise?
Notes: ____

Health History (please answer all questions):
Have you ever or do you currently have the following:

Orthopedic (Injury To or Pain In):
☐ Yes ☐ No Neck or Spine ☐ Yes ☐ No Knees
☐ Yes ☐ No Shoulders ☐ Yes ☐ No Ankles
☐ Yes ☐ No Elbows ☐ Yes ☐ No Lower Back
☐ Yes ☐ No Wrists ☐ Yes ☐ No Arthritis
☐ Yes ☐ No Hips ☐ Yes ☐ No Scoliosis
Explain: ____

Cardiovascular Risk:

☐ Yes ☐ No High Blood Pressure ☐ Yes ☐ No High Cholesterol
☐ Yes ☐ No Cigarette Smoking ☐ Yes ☐ No Diabetes Mellitus
☐ Yes ☐ No Difficulty Breathing ☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Shortness of Breath ☐ Yes ☐ No Sedentary Lifestyle
☐ Yes ☐ No Dizziness ☐ Yes ☐ No Irregular Heart Rate
☐ Yes ☐ No Heart Murmur ☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Family History of Heart Disease
☐ Yes ☐ No Heart Surgery

Explain: ____

Physician's Release Form Obtained: ____________ Date: _________

Notes: ____

Other Conditions:

☐ Yes ☐ No Asthma ☐ Yes ☐ No Hernia
☐ Yes ☐ No Seizures ☐ Yes ☐ No Recent Illness
☐ Yes ☐ No Allergies ☐ Yes ☐ No Vision Problems
☐ Yes ☐ No Hearing Problems ☐ Yes ☐ No Ear Problems
☐ Yes ☐ No Thyroid Disorder ☐ Yes ☐ No Hypoglycemia
☐ Yes ☐ No Pregnancy

Surgeries (Date): ________

Date of last Physical: ___________

Medications: ____

Any Other Medical Conditions: _______________________________________

Assessments:

Height: _____ft. _____in. Weight: _____lbs.

Current Heart Rate (bpm): _____

Current Blood Pressure (mm Hg): _____

Sit and Reach Box (in.): 1. _____ 2. _____ 3. _____

ROM (Range of Motion)/Flexibility Assessment: ________________________

____

____

Circumference Measurements (in.):

Shoulders: _____ R Upper Arm: _____ L Upper Arm: _____ Chest: _____

Waist: _____ Hips: _____ R Thigh: _____ L Thigh: _____

R Calf: _____ L Calf: _____

Work Out Notes:

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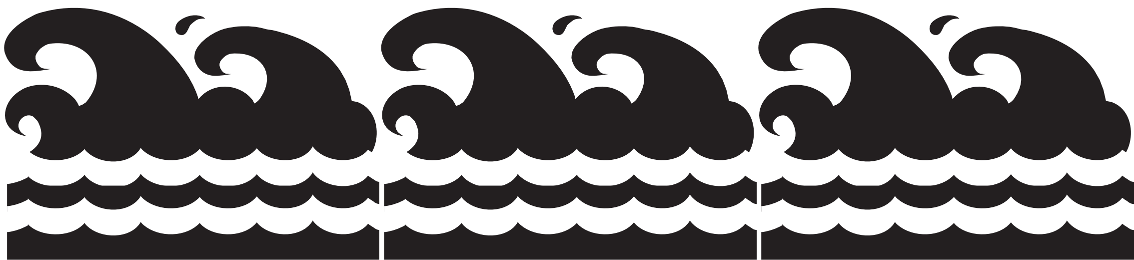
Suggested Exercises:

Suggested Stretches:

Aquatic Orientation



NAME: ______________________

APPOINTMENT DATE/TIME: ______________________