



ROSE BOWL AQUATICS CENTER

THERAPY PROGRAMS INTAKE PACKET

Thank you for choosing the Rose Bowl Aquatics Center (RBAC) for your Aquatic Therapy and Wellness needs. We are here to ensure that you receive the highest quality instruction and benefits from all we have to offer. Whether you are complimenting your existing Physical Therapy routine, looking to work with a Physical Therapist, participate in our swim program, rehab classes or work as an independent, this packet contains the information and necessary paperwork to get you started in aquatic physical therapy. Please read completely and if you have any questions do no hesitate to contact us.

***Please return all enclosed materials to Lori Birmingham in the Therapy Office.
You may fax to (626) 470-9646 or email to lbirmingham@rosebowlaquatics.org***

Lori Birmingham
Therapeutic Programs
Office Manager
(626) 564-0330 x425

Jamie O'Connor, PT, DPT
Therapeutic Programs
Director
(626) 564-0330 x425

Rose Bowl Aquatics Center
360 North Arroyo Blvd, Pasadena, CA 91103
Phone: (626) 564-0330 Fax: (626) 470-9646 www.rosebowlaquatics.org
A Non-Profit Facility Serving All Members of Our Diverse Communities

Scheduling the First Appointment

Once you have completed the Intake Packet and returned it to the Therapy Office, you will be contacted to set up a Screening/Orientation. This takes approx. 20 minutes wherein various therapy options will be discussed to help determine the type of physical therapy that is best suited for your needs.

All patrons wishing to use the therapy pool must be cleared by the Therapy Office before being allowed to enter the pool.

Cancellation Policy

Private Sessions & Community Based Classes:

- Cancellations of more than 12 hours before a scheduled appointment will be credited to your Rose Bowl Aquatics Center (RBAC) account
- Cancellations after 12 hours require a doctor's note to receive credit or a refund
- There are no make-ups or refunds for no show, unexcused, or missed appointments
- Please call the Therapeutic Programs Office at (626) 564-0330 extension **425** and leave a detailed message with your name, time of session, and instructor's name.
- In the event that the RBAC cancels your session, (i.e. due to Rose Bowl events, inclement weather, pool closures, instructor availability, etc.) you will receive credit for that session
- Rescheduling of cancelled sessions must be made directly through the Therapeutic Programs Office.

ROSE BOWL AQUATICS CENTER
THERAPY PROGRAMS ADULT INTAKE PACKET

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Address: _____ City, State, ZIP: _____

Date of Birth: _____ Gender: _____ Male _____ Female

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Diagnosis: _____

Occupation: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

HOW DID YOU FIND OUT ABOUT US?

- Friends or Family member RBAC Member Former Patient
 Website Physician Other _____

WHY ARE YOU HERE TODAY?

- Rehab classes (hip & knee, spine hab, etc.) Community Based Class (Arthritis, Poolates)
(Doctor's Prescription Required) Private Sessions (Doctor's Prescription
Required)
 Physical Therapy Evaluation (Fee and Doctor's Other _____
Prescription Required)
 Independent Workout

REFERRING PHYSICIAN:

Name: _____ Phone: _____

ALL OTHER PHYSICIANS:

Name: _____ Speciality: _____ Phone: _____

Name: _____ Speciality: _____ Phone: _____

Have you had Physical Chiropractic Therapy in the past year? Yes No

Please check and of the following whose care you are under:

- Medical Doctor
- Physical Therapist
- Psychiatrist/Psychologist
- Dentist
- Osteopath
- Chiropractor
- Other _____

If you have seen any of the above in the past three months, please describe for what reason (illness, medical condition, physical, etc.) _____

Have you ever been diagnosed as having any of the following conditions? (Please Circle)

Y N Do you wear external protection garments for bladder leakage or incontinence? ____ Day ___Night

Y N Do you have stress or urgent incontinence?

Y N Cancer. If yes, describe what kind and date of diagnosis: _____

Y N Heart Attack

Y N Rheumatoid Arthritis

Y N Heart Arrhythmia

Y N Other Arthritic Conditions

Y N Heart Valve Problems

Y N Fibromyalgia/Chronic Fatigue

Y N Do you have a pacemaker

Y N Depression

Y N Deep Venous Thrombosis (Blood Clots)

Y N Hepatitis

Y N High Blood Pressure

Y N Stroke

Y N Circulation Problems

Y N Kidney Disease

Y N Asthma

Y N Anemia

Y N Emphysema/Bronchitis

Y N Epilepsy/Seizures

Y N Chemical Dependency (i.e. alcoholism)

Y N Osteoporosis/Osteopenia

Y N Thyroid Problems

Y N Dementia

Y N Diabetes

Y N Other _____

Y N Multiple Sclerosis

Please list any injuries, surgeries, or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization:

Date:	Reason for Hospitalization/Surgery:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Please list any PRESCRIPTION medications you are currently taking (pills, injections, skin patches, etc)

Please list any OVER-THE-COUNTER medications you have taken during the past week:

Y N Aspirin	Y N Antihistamines
Y N Tylenol	Y N Antacid
Y N Advil/Motrin/Ibuprofen	Y N Other
Y N Laxatives	_____
Y N Decongestants	

General Health Questions:

Y N During the past month have you been feeling down, depressed, or hopeless?
Y N Do you smoke cigarettes? How many cigarettes do you smoke per day? _____
Y N Do you chew tobacco?
Y N WOMEN: Are you currently pregnant or think that you might be pregnant?

Do you require an ambulatory device? YES NO

Please indicate: Cane Walker Wheelchair Other: _____

How many caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many days per week do you drink alcohol? _____ Average # of drinks per sitting? _____

Have you recently noticed any of the following:

Y N Weight Loss/Gain

Y N Weakness

Y N Nausea/Vomiting

Y N Fever/Chills/Sweats

Y N Fatigue

Y N Numbness/Tingling

Are you fearful of the water? YES NO

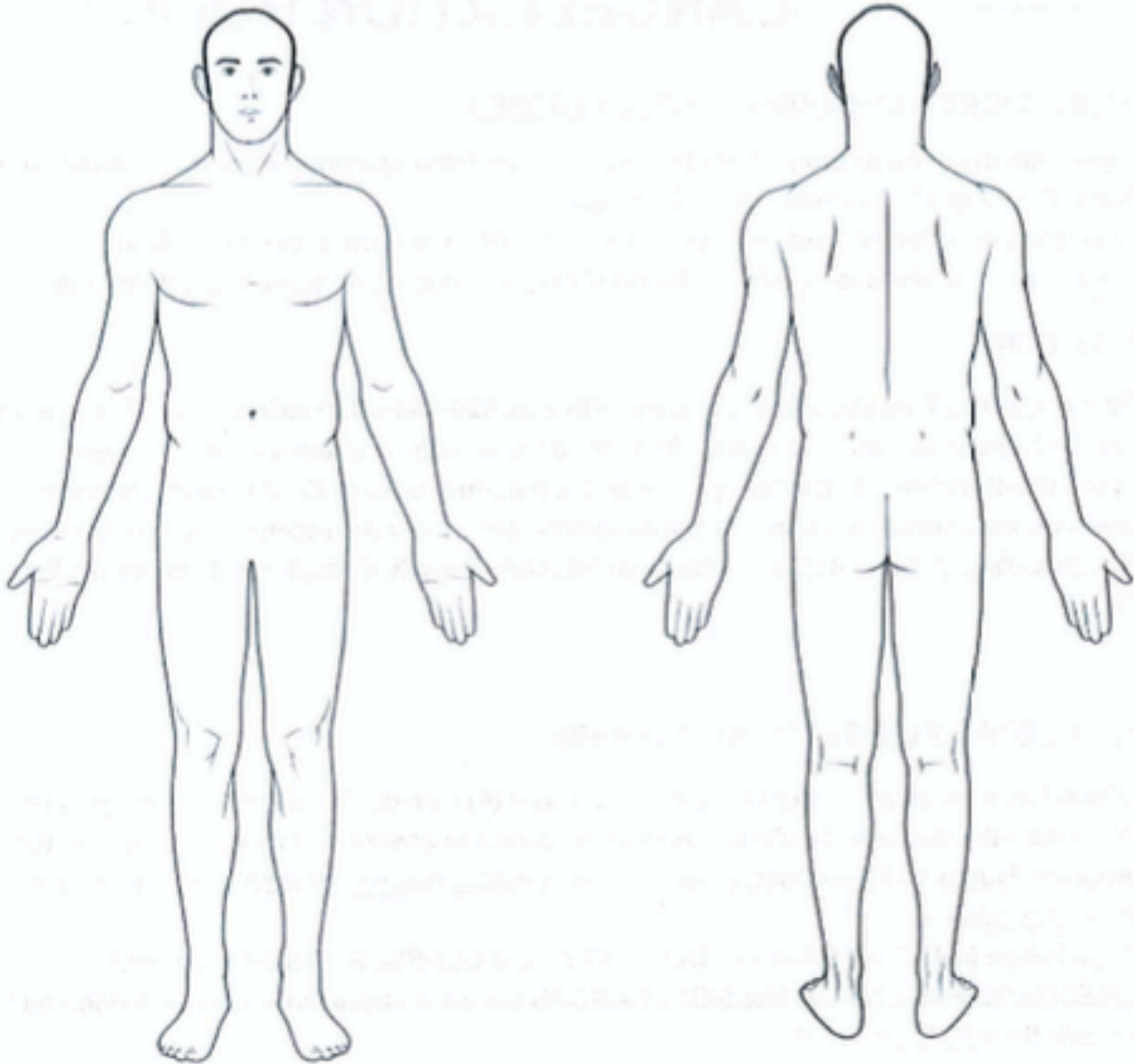
Goals: Why are you coming here? What activities do you want to get back to?

Patient's Signature

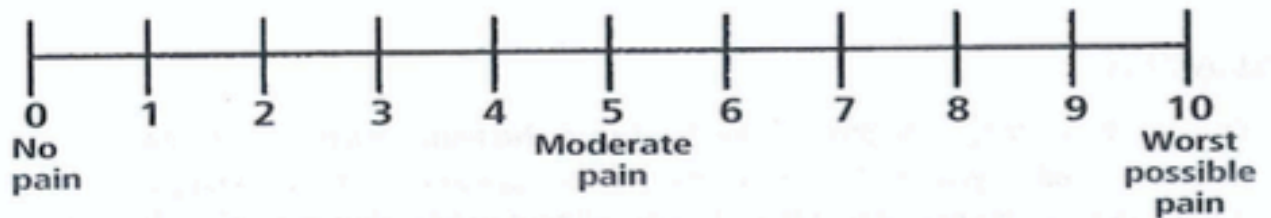
Date

Where is Your Pain?

Please mark, on the drawing below, the areas where you feel pain.



0 – 10 Numeric Pain Rating Scale



Therapy Pool Cancellation Policy

PRIVATE SESSIONS & COMMUNITY BASED CLASSES:

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- There are no make-ups or refunds for no show, unexcused, or missed appointments

CANCELLATIONS:

- Please call the **Therapeutic Programs Office at (626) 564-0330 ext 425** and leave a detailed message with your name, the time of the session and the instructor's name.
- In the event that the RBAC cancels your session, (i.e. due to RBAC events, inclement weather, pool closures, instructor unavailability, etc) you will receive credit for that session
- Rescheduling of cancelled sessions must be made directly through the Therapeutic Programs Office

HIP & KNEE/SPINE REHABILITATION CLASSES:

- Offered as a package of eight classes for four weeks. These classes are progressive, therefore attendance in all classes is recommended to ensure continued progress in the program. Number of participants per class is limited, class registration is on a first come basis. Waitlist available.
- Registration **MUST BE PAID IN FULL FOR ALL 8 CLASSES. THERE ARE NO CREDITS/ REFUNDS FOR MISSED CLASSES** unless a physician's note excusing you from aquatic therapy is provided.
- If you must be absent at any time during the session, as a courtesy, please contact the Therapeutic Programs Office to notify your instructor

WITHDRAWALS:

- One withdrawal from a monthly session is allowed. No refund will be issued, but you will receive a credit on your RBAC account that can be applied to the next monthly session.
- **If you miss 2 or more consecutive classes without notification you will automatically be withdrawn from the session. No refund or credit will be given.**

Rose Bowl Aquatics Center Photo Release Form

I hereby consent to the use, reproduction, editing, and/or broadcast by the Rose Bowl Aquatics Center (RBAC) of any and all photographs, video and/or audio recordings of me taken by or on behalf of the RBAC, from this day, without compensation to me. All digital images, print, negatives and positives, video-recorded images and audio recordings shall constitute the property of RBAC solely and completely. If you DO NOT CONSENT, cross out the entire form and DO NOT SIGN.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below and full understand the contents, meaning, and impact of this release.

NAME (PLEASE PRINT CLEARLY)

SIGNATURE DATE

If the person signing is under 18, there must be consent by a parent or guardian as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

PARENT/GUARDIAN'S PRINTED NAME

PARENT/GUARDIAN'S SIGNATURE DATE

PHONE NUMBER

ROSE BOWL AQUATICS CENTER PRIVACY OF HEALTH INFORMATION

As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices. I understand that the Rose Bowl Aquatics Center (referred to below as "the Center") will use and disclose health information about me in the course of providing physical therapy care to me. I understand that my health information may include information both created and received by the Center, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types or health-related information.

I understand that the Center is permitted to use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult, and coordinate with other health care providers in the course of my treatment; determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative, and business functions that support the center's ability to provide me with appropriate care and arrange for payment

I also understand that I have the right to receive a written Notice of Privacy Practices which describes how the Center uses and discloses health information, the information practices followed by the Center staff and my rights regarding my health information. I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

By signing below, I agree that I have reviewed and understand the information above and that I have received or can access a copy of the Notice of Privacy Practices.

By (Patient):

PRINT: _____ SIGNATURE: _____ DATE: _____

OR By (Patient Representative)

PRINT: _____ SIGNATURE: _____ DATE: _____

Description of Representative's Authority: _____

HEALTH INFORMATION RELEASE FORM

I, _____, hereby allow the Rose Bowl Aquatics Center to request and receive the release of any protected health information regarding my treatment or administrative operations related to treatment from my referring physician of record. I give my permission to the Rose Bowl Aquatics Center to release information, verbal and written, from my medical record to my referring physician of record as it relates to my treatment.

Patient Signature: _____

Date: _____

I, _____, authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I give my permission to the Rose Bowl Aquatics Center to release information, verbal and written, from my medical record to the designated parties as it relates to my treatment. If none, please print "none" below.

Authorized Designees:

(Example Name: Dr. Bones)

(Example Relationship: Chiropractor)

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Patient Signature: _____

Date: _____