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**ARTHRITIS AQUATIC PROGRAM
PARTICIPANT APPLICATION FORM (FORM 1)**



Date: _____	Name: _____	Age: _____
Address: _____ _____		
Home Phone: _____	Work Phone: _____	

Emergency Contact Phone: _____	Name: _____
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Type of Arthritis: _____

Which session are you applying for:

1st choice _____
2nd choice _____
3rd choice _____

How did you become aware of this Program? _____

Please indicate if you have experienced any of the following conditions:

			<i>If applicable, explain</i>
Problems with bladder/bowel control	___ No ___ Yes		_____
Skin lesions/open wounds/athlete's foot	___ No ___ Yes		_____
Seizures – epileptic	___ No ___ Yes		_____
Fainting spells	___ No ___ Yes		_____
Problems with blood pressure	___ No ___ Yes		_____
If yes, <i>High blood pressure</i> <input type="checkbox"/>			
<i>Low blood pressure</i> <input type="checkbox"/>			
Heart condition (e.g. angina)	___ No ___ Yes		_____
Diabetes	___ No ___ Yes		_____
If yes, <i>do you require insulin?</i>	___ No ___ Yes		_____
Breathing Problems (e.g. asthma)	___ No ___ Yes		_____
Deafness	___ No ___ Yes		_____
Limited vision	___ No ___ Yes		_____
Poor balance	___ No ___ Yes		_____

Are you independently mobile? ___ No ___ Yes _____

Other medical conditions or symptoms that may affect participation in the Program:
___ No ___ Yes If yes, explain: _____

My Doctor is: _____ Dr.'s Telephone No. _____

***Please attach: Physician Consent Form, Participant's Release Form, payment.

Reviewed by: _____ Date: _____
