Paul H. Broyhill
Wellness Center

Aquatic Arthritis Accountability Statement

You and your healthcare provider have decided that our chronic pain classes would be of great benefit to you in order to improve your overall health. As a committed member of this program, you will receive a tight-knit support system and a significant amount of resources to help you improve your health and quality of life through warm water therapy.

Program goal

- Improved flexibility
- Improved joint range of motion
- Increased aerobic endurance
- Reduced pain associated with inflammation
- Improve quality of life

Your role while participating in the Aquatic Arthritis: Program standards

- A physician referral, physical therapy referral, or occupational therapy referral is required for program participation. The participant must obtain the referral; from a physician prior to program registration. Qualifying diagnoses include: arthritis, fibromyalgia, and chronic pain.
- You are responsible for payment at registration. Payment should be received by the 15th of each month to avoid any late charges.
    - Members: $40 for 8 classes
    - Non-Members: $60 for 8 classes
- If you wish to discontinue at any point, you are responsible for notifying the member manager in writing. Should a medial issue arise, a one-month medical leave of absence will be approved. Upon return, a physician's medical clearance is required. Failure to notify the membership manager will result in full payment of monthly dues. No refunds will be issued.
- Arthritis class times:
    - Monday, Wednesday, Friday 11:00am-12:00pm & 3:00pm-4:00pm
    - Tuesday & Thursday 11:00am-12:00pm; 1:00pm-2:00pm & 2:00pm-3:00pm
        - ❖ If you sign up for one of the above class times, we ask that you call the front desk to cancel your reservation if you are unable to attend. Failure to cancel your reservation will result in a class session being deducted.

Failure to meet the above standards, will result in voluntary dismissal from the program.

Acknowledgement of my commitment

I do hereby attest that I have read and understood the above information. I further acknowledge and understand that I am responsible for communication with the membership manager if I must discontinue the program for any reason.

Participant Signature _____ Date _____

Witness Signature _____ Date _____

Paul H. Broyhill Wellness Center	Patient Name _____ Date of Birth _____ Phone Number _____ Please Fill in or Affix a Patient Label

Arthritis Aquatic Program Application

First:	MI:	Last Name:	Sex (M/F):
DOB: / /		E-Mail:	
Mailing Address:			
City:	State:	Zip:	
Home Phone #:		Business/Cell Phone #:	
Emergency Contact (Local) Name:	Emergency Contact Home #:	Emergency Contact Cell #:	

1. Do you have arthritis? If yes, what type?
   - ☐ Yes
   - ☐ No

2. How did you find out about the Arthritis Program held here at the Wellness Center?

3. My current activity level: (Check only one.)
   - ☐ I have a lot of joint limitation or many joints affected by arthritis and am not very physically active.
   - ☐ I only have minor joint problems but have weak muscles or get tired easily. I have been doing some exercise or physical activity.

4. Physician (Local):	5. Physician's Fax #:
6. Do you walk with assistive devices? If yes, what type? ☐ Yes ☐ No	7. Are you a member of the Wellness Center?

Patient Name _____
Date of Birth _____
Phone Number _____
Please Fill in or Affix a Patient Label

Medical Questionnaire

CATEGORY ONE	YES	NO	CATEGORY THREE (cont.)	YES	NO
A. Are you age 40 or older?	☐	☐	Has a physician ever told you that you have/had:		
B. Do you smoke 10 or more cigarettes a day?	☐	☐	G. Cardiovascular disease (heart disease, stroke) or peripheral vascular disease?	☐	☐
CATEGORY TWO			H. Diabetes	☐	☐
A. Do you have a family history of cardiovascular disease prior to age 55 in parents or siblings?	☐	☐	I. Pulmonary Disease?	☐	☐
B. Has a physician ever told you that you have high cholesterol (>240)?	☐	☐	J. Metabolic Disease?	☐	☐
CATEGORY THREE			K. Heart Attack?	☐	☐
A. Are you pregnant?	☐	☐	M. Have you ever had orthopedic surgery?	☐	☐
B. Do you experience dizziness?	☐	☐	N. Have you had surgery in the past year?	☐	☐
C. Do you experience skipped heart beats or a very rapid resting heart rate?	☐	☐	O. Are you currently under the care of a physician for a medical condition?	☐	☐
D. Do you experience ankle swelling	☐	☐	P. Do you have an orthopedic problem?	☐	☐
E. Do you experience discomfort breathing while lying down or wake up suddenly gasping for air?	☐	☐	Q. Do you have any paralysis or current neuromuscular involvement due to multiple sclerosis, stroke, or other condition?	☐	☐
F. Do you experience chest pain?	☐	☐			

Please list any medications.

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I certify that all answers and statements listed in this application and medical screening questionnaire are my own and are true to the best of my knowledge. I understand that misinformation or false statements may result in revocation of this application or membership resulting there from. I understand that scoring 3 or more points on the Wellness Medical Screening Questionnaire requires a physician recommendation for membership and participation in the Arthritis Aquatic Program held at the Paul H. Broyhill Wellness Center.

Signature of Applicant: _____ Date: _____ Time: _____