PURPOSE
Filled Fitness

Exercise Approval Form

Your Patient_____has applied to participate in our exercise/wellness program. Before beginning the program an assessment is performed, this assessment will provide the exercise specialist information on total body structural alignment, flexibility, muscle strength, range of motion, balance, and neuromuscular control. An individual program will be developed for your patient to achieve his/hers health and wellness goals.

Please list any medications that could affect his/her heart rate response.

_____
_____

Please list any restrictions, modifications, or recommendations.

_____
_____
_____

Please list any special concerns you may have regarding this patient (i.e, arrhythmia, fine motor problems, neuropathy, low-back issues, arthritis, etc.,)

_____
_____
_____

Please list target heart rate, rate of perceived exertion, or general exercise intensity

_____

My Patient_____, has my approval to enroll in a exercise/wellness program with Purpose Filled Fitness with the above restrictions, modifications and recommendations.

PHYSICIANS SIGNATURE_____ DATE_____

E:Mail ADDRESS_____

PHONE _____

Purposefilledfitness@gmail.com
www.purposefilledfitness.com
Phone: 301-751-9995