



# Fitness Matters

Discover a Balanced Approach to Fitness

## PHYSICIAN APPROVAL FOR PHYSICAL ACTIVITY

Client/Patient \_\_\_\_\_ Date \_\_\_\_\_

Your patient has voluntarily decided to engage in a one-on-one personal training exercise program with FitnessMatters Inc. The primary objective of our program is the promotion of holistic health and fitness through personally prescribed physical activity. A certified Personal Fitness Specialist will design the individualized exercise program.

The program includes periodic physical fitness assessments and supervised exercise. The supervised exercise programs include aerobic, muscle, flexibility, and balance conditioning. All programs follow the guidelines established by the American College of Sports Medicine, unless otherwise specified. All Personal Fitness Specialists are certified in CPR, Fitness First Aid, and hold national certifications. Fax to 860-927-7913

Please indicate below if your patient has any of the following medical conditions:

- Coronary heart disease \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- High Cholesterol \_\_\_\_\_
- Reactive Airways Disease \_\_\_\_\_
- Knee/Back Ailments or Recurring Problems \_\_\_\_\_
- Peptic Ulcer Disease \_\_\_\_\_
- Musculoskeletal Disorder \_\_\_\_\_
- Diabetes \_\_\_\_\_

Could you please add any other medical condition or exercise contradictions we need to be aware of in monitoring this client's progress and response to the exercise program?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your patient will engage in the following physical activities: (Initial if OK)

- Aerobic Exercise (bike, treadmill, etc.) \_\_\_\_\_ OK \_\_\_\_\_
- Muscle Conditioning \_\_\_\_\_ OK \_\_\_\_\_
- Flexibility Exercises \_\_\_\_\_ OK \_\_\_\_\_
- Balance Exercises \_\_\_\_\_ OK \_\_\_\_\_
- Abdominal/Lower Back Strengthening \_\_\_\_\_ OK \_\_\_\_\_
- Would you like to receive monthly progress reports or to have your patient communicate his/her progress at an office visit? Report \_\_\_ Office Visit \_\_\_

(Patient's Name) \_\_\_\_\_ is under my care and has my permission to begin a supervised exercise program with FitnessMatters Inc. My patient is currently working with a physical therapist. That person's name is \_\_\_\_\_, the office he/she is associated with is \_\_\_\_\_, and the phone number is \_\_\_\_\_.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_