Letter of Medical Clearance for Intensive Exercise

Dear Medical Physician;

Your patient is being referred to our Gym Membership program. This program consists of range of motion, strengthening, functional performance activities and sports related drills and function.

If you believe your patient will benefit from our program please fill out the attached form.

If you have any additional questions please feel free to contact us.

Thank you for your time.

Sincerely,

Angelica Gomez
Exercise Therapist/Founder
Allternative Gym
1365 Pritchett Industrial Blvd.
Austell, Ga. 30168
678-945-4662
offices@allternativegym.com
www.allternativegym.com

Patient name: ______________________________________ Date of Birth: ________________

Diagnosis: ____

Physician's name: ____

Physician's address:____

Physician's phone: ________________________________

Please review the following conditions and check any that apply:

Cardiac conditions? ___________
If yes, please describe ____

High blood pressure? ____
Have a shunt? ____

History of fractures? ____
Bone conditions? ____
Hip subluxation? ___________

Please write degree of subluxation for: Right _____ Left ______

Would you recommend a bone density test prior to an intensive therapy session? _______

Seizures? ___________ Are they controlled by medicine? __________
Date of last seizure___________________

Respiratory conditions? ____
Scoliosis? ___________ Degree of curvature? ________________

Diabetes? ______________________

Kidney problems? _______________________________________

Any other conditions not mentioned in which precautions need to be taken or would make the intensive therapy contraindicated?
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____

I recommend this patient participate in a program at Allternative Gym.

____________________________________ _____________________
Physician's Signature Date