Physician's Clearance

Physician's Name: _____
Physician's Address: _____
Physician's Phone Number: _____

Patient's Name: _____

I have been treating this patient since _____ for the following
Date

Conditions(s): __ High Cholesterol __ High Blood Pressure
__ Diabetes __ Obesity
__ Osteoporosis __ Osteopenia
__ Stress __ Hyperthyroidism
__ Joint Pain __ Back Pain
__ Other: _____

He/She is cleared for exercise/massage with: __ limitations (see below)
__ no limitations

_____

_____

_____

Please list any prescribed medications and any contraindications to exercise/massage:

_____

_____

_____

_____

_____

Physician's Signature: _____ Date: _____

Send to: ***Fit For Life***
1130 N. Nimitz Hwy, Suite A-140
Honolulu, Hawaii 96817
Phone: 808-535-1550
Fax: 808-356-0146
email: info@fitforlifehawaii.com

Client's Name: _____
Ph. #'s H/W: _____
C : _____
email: _____