

Patient Information



Name _____

Birthdate _____

Address _____

City/State _____

Phone Number _____

Email _____

Date _____

Choose Your Program: Option 1 \$150 Option 2 \$299

REQUIRED INFORMATION

Please check one of the following:

- Patient is cleared for unsupervised exercise
- Patient is cleared only for water exercise
- Patient is cleared for exercise under the following conditions

Diagnosis: _____

Restrictions: _____

Recommended Exercise Prescription:

- Cardiovascular Conditioning
- Strength Training
- Aquatic Exercise
- Progressive increase in training at the discretion of the trainer
- Do not exceed age predicated maximum heart rate
- Increase duration and intensity of workout
- Lose Weight
- Nutrition Counseling
- Improve Flexibility

HEALTHCARE PROVIDER INFORMATION

Name _____

Street Address/ City/State/ZIP _____

Phone/Fax _____

Email _____

Date _____

This form can be emailed to our Briarcliff location at bradvisor@clubfit.com

—OR—

our Jefferson Valley location at jyadvisor@clubfit.com

PLEASE STAMP