

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):	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> High Blood Pressure
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Obesity
	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Osteopenia
	<input type="checkbox"/> Stress	<input type="checkbox"/> Hyperthyroidism
	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Back Pain
	<input type="checkbox"/> 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**

801 Dillingham Blvd. Suite 101
Honolulu, Hawaii 96817
Phone: 808-535-1550
Fax: 808-535-1560
email: fit4lifehawaii@hawaiiantel.net

Contact Name: _____

Phone Number(s): _____

email: _____