ADAPTIVE

A/M

MOVEMENT

Medical Release Form

Dear Doctor:

Your patient, _____, wishes to start a personalized training program. The activity will involve the following:

Type: functional movement, balance, resistance, and cardio-respiratory training, yoga, and self-myofascial release.

Frequency: 1-4 days per week
Duration: 50 minutes
Intensity: low - moderate

If your patient is taking medications that will affect his or her exercise capacity or heart-rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect on exercise capacity or heart-rate response):

Medication types:
_____

Effects:
_____

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:
_____
_____
_____

Thank you sincerely,
Jason DellaValle
adaptivemovementllc@gmail.com - 202 854 0287
_____

_____ has my approval to begin an exercise program with the recommendations and restrictions stated above.

Print: _____
Signature: _____ Date: _____ Phone: _____