WELLNESS CLEARANCE FORM

____ would like to participate in the Cantrell Center's Wellness Program. The Cantrell Center provides the opportunity for individuals to meet personal goals with the guidance of our experienced staff.

Individuals who wish to participate in the Cantrell Center's wellness program must receive clearance from a physician.

Please complete the attached form for this patient, utilizing the list of critical areas provided. This information will enable us to tailor a specific wellness program for this client.

WATER AEROBICS **NUTRITIONAL COUNSELING** **SPORTS MEDICINE** **WEIGHT MANAGEMENT**

The Cantrell Center for Physical Therapy and Sports Medicine ▪ 405 Osigian Boulevard ▪ Warner Robins, GA 31088
(478) 333-6777 ▪ Fax: (478) 953 – 0353 ▪ www.cantrellcenter.com

I have examined _________________________________ and have found to be in good health and ready to participate in a personalized wellness program.

__ Weight Control
__ High Cholesterol
__ Elevated Serum Triglycerides

__Diabetes
__Arthritis
__Hypertension

__Transplant
__Joint Replacement
__Endurance Training

__Pediatric Weight Control
__Osteoporosis/Osteopenia
__ Incontinence*
*Bowel / Bladder

Patient Information:

DOB:______________________________Contact #:____

Comments/Special Instructions:

____

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____

Physician Signature **Date**

Physician Name Printed____

Phone: ______________________ Fax: _____________________________