



UPRIGHT MOVEMENT

Defy Gravity

Date _____

Dear _____

Your patient, _____ would like to begin an exercise program with UpRight Movement. To promote the greatest safety and positive results, we interview each client to assess for "risk factors". We have identified some of those risk factors checked below.

- | | |
|--|--|
| <input type="checkbox"/> Elevated blood pressure | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Leg cramping |
| <input type="checkbox"/> Tachycardia, palpitations, or heart murmur | <input type="checkbox"/> Previous stroke |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Family history of heart disease |
| <input type="checkbox"/> Diagnosed cardiac, pulmonary disease | <input type="checkbox"/> Abnormal EKG |
| <input type="checkbox"/> Bone, joint, back or muscular problems | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Lung, thyroid, kidney or other metabolic disease | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Swelling of the ankles |
| <input type="checkbox"/> Fainting spells or dizziness | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Over 60 years of age (not accustomed to exercise) | <input type="checkbox"/> Other, answered YES to other listed question on |
- Should this person exercise? Yes No
Past Medical History Questionnaire
Is light to moderate weight training permissible? Yes No

Maximum training heart rate:

Please list any restrictions, recommendations or any other comments concerning your patient.

Physician's signature

Date

Thank you for your time.

Performance Specialist

Date

UpRight Movement | www.uprightmovement.com | 800.921.4512