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To schedule an appointment,  
 please call 651-646-4045  
 or fax to 651-645-2735 (include patient phone #)

**Patient should bring this prescription and insurance information to the first Personal Fitness Systems appointment.**  
 Insurance reimbursement may require a referral from the patient's primary care clinic or prior authorization from the insurance provider.

**Patient Name** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Phone** \_\_\_\_\_

**Diagnosis** \_\_\_\_\_ **Date of onset:** \_\_\_\_\_

**Other pertinent health conditions** \_\_\_\_\_

**Check one of the following services:**

- |                                       |
|---------------------------------------|
| 1. _____ Fitness training program     |
| 2. _____ Fitness testing              |
| 3. _____ Massage up to _____ sessions |

**Physician name:** \_\_\_\_\_ **Clinic** \_\_\_\_\_

**Physician signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Please indicate which conditions the patient requires treatment for:**

<input type="checkbox"/> <b>Fitness training</b>	<input type="checkbox"/> <b>Fitness testing</b>	<input type="checkbox"/> <b>Massage</b>
_____ weight loss	_____ body composition	_____ arthritis
_____ decreased aerobic endurance	_____ heart rate recovery	_____ asthma
_____ decreased muscle endurance	_____ muscle endurance	_____ back pain/neck pain
_____ decreased muscle strength	_____ flexibility	_____ carpal tunnel
_____ decreased flexibility		_____ chronic pain
_____ arthritis		_____ chronic fatigue
_____ back pain/neck pain		_____ depression
_____ carpal tunnel		_____ fibromyalgia
_____ chronic fatigue		_____ headaches
_____ chronic pain		_____ hypertension
_____ depression		_____ insomnia
_____ diabetes		_____ migraines
_____ hypertension		_____ multiple sclerosis
_____ fibromyalgia		_____ spinal cord injuries
_____ other _____		_____ other _____