Tai Chi & Chi Kung Institute ®

GPO Box 66, Adelaide, 5001

Email: office@taichi.com.au www.taichi.com.au

38 years in SA.
All instructors are Accredited at the Beijing Sports University

Doctor & Practioner Approval Form

Tai Chi or Chi Kung Classes

Doctor's Name...

Address.. Post Code... ... ...

Telephone:........................ ...... Email: ....

Thank you for providing the following information about your patient who wishes to attend **Tai Chi** *(slow/safe movements)* **and/or Chi Kung** *(easy relaxing exercise)* classes with the Tai Chi & Chi Kung Institute.
Colour brochure about the Institute available by clicking this link: www.taichi.com.au/aboutus.pdf

All information is <u>strictly confidential</u> and available only to the Instructors <u>immediately</u> involved in teaching your patient. This information is used to provide the Instructor with accurate information in case of emergency and to insure their awareness of your patient's medical condition.

For more information about our classes, please see the 'What is Tai Chi / Chi Kung?' and 'What is Chi Kung?' sections of our web site at www.taichi.com.au
***Please note**: Chi Kung is much easier and less physically demanding than Tai Chi.*

Please comment on any medical conditions that may affect your patient's participation in a Tai Chi or Chi Kung exercise class.

Medical Conditions:

- ❑ Arthritis
- ❑ Asthma
- ❑ **Back**
- ❑ Bipolar
- ❑ Blood Pressure
- ❑ Cancer
- ❑ Chronic Fatigue
- ❑ **Covid**
- ❑ Heart
- ❑ **Lung**
- ❑ **Neck**
- ❑ Pregnant
- ❑ Stress
- ❑ Other...

Does this patient require an assessment by a physiotherapist prior to joining our Tai Chi or Chi Kung classes? Yes / No

Are there any movements that should be avoided? Yes / No

If yes, name these movements: ....
....

Is there any other relevant information that might affect treatment in an emergency situation?
....

Is this patient currently taking any <u>medication</u> that would affect them doing exercise? Yes / No ....

I advise that (Client's Name) .... **is medically fit to participate in Tai Chi or Chi Kung exercises. I have read the Tai Chi & Chi Kung Institute Brochure or Website information which explains these exercises.**

Doctor's / Practitioner's Signature: .... **Date**..................
Doctor's Address / Stamp.

Updated January2023

[OFFICE USE ONLY - VENUE: ______________________________TERM /YR: _____ / _____ SET/SECT: _____ /_____]