Patient Fitness Progress Report

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Name: ______________________ DOB:__________ MRN#: __________

Primary/Referring Healthcare Provider:______________________________

Medical Diagnoses:______________________________

Activity location (fitness facility, home, etc.): ______________________________

Initial Assessment (date): ______________ Follow-up visits (dates):______________

Exercise(s) Recommended and Actual

	Recommended	Actual
Frequency		
Intensity		
Time		
Type		

Summary of Progress to Date/Goals Met

Physical Activity Plan

Exercise Professional: ______________ Phone: __________ Email:__________
(Signature)

I have reviewed this plan of treatment and re-certify a continuing need for fitness training services.

❑ I certify the need for these services furnished under this plan of treatment and while under my care.

❑ Revise physical activity plan as follows:

❑ Discontinue plan

Referring health care provider: ______________________ Date: __________
(Signature)

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