

Patient Fitness Progress Report

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)

