Initial Fitness Assessment/Physical Activity Plan

Name: _____ DOB: _____ MRN#: _____

Primary/Referring Physician: _____

Primary Diagnoses: _____

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

Current level and physical activity history:

Patient's Goals:

Initial Assessment:

Baseline Fitness/Functional Assessments:

Physical Activity Plan

Frequency:

Intensity:

Type:

Time:

Short-term/Long-term Goals:

Comments/Questions for Provider:

Exercise Professional: _____ Phone: _____

Email: _____

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