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:_____