

Patient Fitness Progress Report

Exercise
is Medicine®

AMERICAN COLLEGE
of SPORTS MEDICINE®

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)