

EXERCISE READINESS & PRESCRIPTION



Patient's name: _____ DOB: _____ Date: _____

Physician's Signature _____

CURRENTLY EXERCISING: Yes No

Type/s of Activity _____

How Hard _____
(Light, moderate, intense)

How Long _____
(Minutes/session)

How Often _____
(Times/week)

PATIENT'S STAGE OF CHANGE

- Precontemplation**
(Patient not ready to exercise)
- Contemplation**
(Patient interested in/beginning to exercise)
- Preparation**
(Patient's exercise inconsistent/less than optimal)
- Action and Maintenance**
(Patient exercising recommended amount)

PHYSICIAN'S RECOMMENDATIONS

Aerobic Exercise _____

Strength Exercise _____

Flexibility Exercise _____

Sports Exercise _____

Referral to Exercise/Sports Professional _____