

Exercise Prescription

Patient Information

Name:

Date of Birth:

Gender:

Contact Number:

Email:

Emergency Contact:

Health Information

Medical History:

Exercise History:

Physical Assessment

Resting Heart Rate:

Blood Pressure:

Body Mass Index (BMI):

Flexibility Assessment:

Strength Assessment:

Exercise Prescription**Cardiovascular Exercise**

Frequency:

Intensity:

Type:

Duration:

Strength Training

Frequency:

Intensity:

Type:

Sets/Reps:

Flexibility Training

Frequency:

Intensity:

Type:

Duration:

Balance and Stability Exercises

Frequency:

Intensity:

Type:

Duration:

Exercise Restrictions**Additional Recommendations**

Hydration:

Nutrition:

Rest and Recovery:

Follow-up Instructions**Healthcare Provider Information:**

Doctor's Signature:

Doctor's Name:

Contact Number:

Name of Hospital/Clinic: