



Exercise Prescription Form

Patient Information

Patient Name: _____ Age: _____ DOB: _____

Patient Phone: _____ Patient Email: _____

Please list any/all medical conditions: _____

Exercise Prescription May Include

DO

- ☐ Cardiovascular Conditioning
- ☐ Mobility Training
- ☐ Strength Training
- ☐ Balance and Flexibility
- ☐ Other: _____

DON'T

- ☐ Cardiovascular Conditioning
- ☐ Mobility Training
- ☐ Strength Training
- ☐ Balance and Flexibility
- ☐ Other: _____

List any precautions/special conditions for exercise: _____

Healthcare Provider Information

Healthcare Provider Name: _____

Referring Healthcare Provider Signature: _____ Date: _____

(required)

To get started or for more information, please call (509) 943-8416.