University Hospitals
Avon Health Center
Fitness
440-988-6801 | UHhospitals.org/Fitness |
1997 Healthway Drive, Avon, Ohio 44011

Post PT Rehab Program Patient Exercise History Form

Instructions

Indicate information below pertaining the patient's status with therapeutic exercises

Patient Information

Patient Name:_____ Date of Birth: _____ Phone:_____

Email:_____(this may be used to communicate about the program)

Start and End Date of Therapy: _____ Procedure Completed:_____

Exercise	Weight /Resistance type	Limitations
Leg curl		
Hip flexion		
Hip extension		
Squat		
Leg raises		
Step ups		
Leg press		
Other:		

Patient Goals/Comments:

Referring Physical Therapist

Name:_____ Signature:_____

Date:_____ Phone:_____/Location:_____

Participant Release Authorization

I hereby authorize release of medical information pertinent to restrictions for my exercise program as determined necessary by my healthcare provider.

PARTICIPANT SIGNATURE_____ DATE_____

Email to: Renee.Barrett@UHhospitals.org or Fax: 440 988 6810