

(Please print boldly)

Patient Name: _____

ACTIVITY PLAN

Clinic name and logo here

Evaluation and Treatment Recommendations

Diagnosis _____ routine health maintenance visit

Onset date of this condition ___/___/___

Blood Pressure _____ within normal limits

Instructions / Plan:

Label here if needed

CONFIDENTIAL

Medication prescribed this visit: _____

Referral Made to: _____

Instructions apply for work, home, and recreation until the next scheduled visit unless otherwise indicated:

NORMAL ACTIVITIES as of ___/___/___ **REST AT HOME** through ___/___/___ or until next scheduled visit

LIMIT ACTIVITIES through ___/___/___ or until next scheduled visit

FILL IN ONLY WHERE THERE ARE LIMITATIONS :

Can Lift / Carry up to _____ lbs. _____ times/hr. _____ hrs. /day No lifting requiring bending No lifting over mid-chest level

Can Push / Pull up to _____ lbs. _____ times/hr. _____ hrs. /day

Can Sit up to _____ minutes at a time for _____ hrs. /day Change positions as needed every _____ minutes

Can Stand up to _____ minutes at a time for _____ hrs. /day

Can Walk up to _____ distance at a time _____ hrs. /day

Can Climb _____ flights of stairs at a time _____ times/day Cannot climb ladders

Can Bend/Twist/Stoop up to _____ times/hr. _____ hrs. /day

Can Squat/Kneel/Crawl up to _____ times/hr. _____ hrs. /day

Can Drive up to _____ minutes at a time _____ hrs. /day Can only drive automatic transmission

Can Grip/Pinch/Grasp: Right Left _____ times/hr. _____ hrs. /day Must wear splint: Right Left

Can Bend/Twist Wrist: Right Left _____ times/hr. _____ hrs. /day

Can Reach Overhead/Out: Right Left _____ times/hr. _____ hrs. /day

Can use Keyboard up to: _____ min/hr. _____ total hrs. /day

OTHER RECOMMENDATIONS:

IF NO LIMITATIONS NOTED YOU CAN PERFORM ACTIVITY AS USUAL

NO FURTHER TREATMENT NECESSARY

RETURN TO CLINIC IN _____ DATE _____ TIME _____

Provider name _____ Provider Signature _____ License Number _____ Date _____

This form is primarily for your personal information and education. Your employer or school will not receive this information unless you choose to provide it to them. You will receive two copies of the Activity Plan. If your doctor limits your regular daily activities and this affects you at your school or work, you may need to give a copy of the form to your school or work. This will help others assist you with necessary job or school activity changes.