

RECOVERY EXERCISE SCHEDULE

Week of: _____

Patient Name: _____

Target Area: _____

DAY	EXERCISE DESCRIPTION	SETS/REPS	COMPLETED
Monday			AM PM
Tuesday			AM PM
Wednesday			AM PM
Thursday			AM PM
Friday			AM PM
Saturday			AM PM
Sunday			AM PM

Physician/Therapist Notes:

Stop exercise immediately if you experience sharp pain or dizziness.