# PROFESSIONI DEL MOVIMENTO E PROMOZIONE DEL BENESSERE: IL CONTRIBUTO DEL CHINESIOLOGO IN UNA PROSPETTIVA BIOPSICOSOCIALE ED EDUCATIVA

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## ABSTRACT

Kinesiologists, human movement professionals with specialization in preventive and adapted physical activity, the promotion of active lifestyles, and wellness management in various public and private settings, possess skills that enable them to design, conduct, supervise, and evaluate educational and rehabilitative physical activity programs aimed at individual and collective wellbeing. Professional practice is grounded in the biopsychosocial model which interprets well-being as the result of the interaction between biological, psychological, social dimensions, and the salutogenic paradigm, which focuses on personal and contextual resources that support the maintenance of health and quality of life also considering the aging of the population. . The appropriate response to the growing complexity of healthcare needs requires greater synergy between sports, education, prevention, and healthcare, with the specific contribution of professions related to the practice of physical activity.

## KEYWORDS

Kinesiologist; health; well-being; quality of life.

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## 1. Introduction

The constant evolution of contemporary society is increasingly directing the pursuit of individual wellbeing towards prevention and a holistic view of quality of life.

The growing complexity of health needs has gradually altered the way in which the relationship between wellbeing, quality of life, prevention and human movement is understood. In contemporary societies, characterised by an increase in chronic degenerative diseases, an ageing population, the spread of sedentary lifestyles and a rise in psychosocial fragility, the concept of health can no longer be reduced solely to the absence of disease or to the mere biological functioning of the body. The World Health Organization introduced an innovative perspective, describing health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (WHO, 1948). Subsequent scientific debate has further expanded this vision, highlighting the dynamic, relational and contextual nature of health and wellbeing processes.

In this context, the aim is to promote healthy lifestyles that counteract the stresses of daily life. This is pursued with the contribution of professionals specialising in fostering psychophysical balance, a condition determined by a range of biological, physiological (Barnosell, 2000), genetic, psychological and environmental factors that vary from person to person.

From this perspective, the biopsychosocial model (Engel, 1977), which interprets wellbeing as the result of the interaction between biological, psychological and social dimensions, takes on particular significance, as does the salutogenic paradigm (Antonovsky, 1996), which focuses attention on the personal and contextual resources that support the maintenance of health and quality of life.

In this view, health is a combination of physical and psychological wellbeing: the ability to feel at ease with oneself and with others, something far broader and more comprehensive than the mere absence of illness.

It follows that looking after one's health and wellbeing is closely linked to quality of life: adopting healthy lifestyles and engaging in regular physical activity (Introna, 2022) contributes significantly to improving cardiovascular, metabolic (Pippi et al., 2024), musculoskeletal, cognitive and psychological health (Bull et al., 2020). The importance of movement-related professions and specialist skills, with a focus on the design, management and promotion of physical activity aimed at health, prevention and wellbeing throughout the lifespan (Agosti & Borgogni, 2024), is therefore considerable.

The Sports Science paradigm (Freccero, 2013), with international references such as Sport Science, Physical Activity, Physical Education and Sport, is the outcome of a methodological, didactic, physical, sporting and regulatory process that originated in the development of the Italian gymnastics movement in the 19th century. It addresses the education and wellbeing of the person (Cereda, 2016) in their entirety, within the psychophysical development achieved through movement, with particular attention to health education (Fabris & Magnanini, 2000) and to the improvement of behaviour with a view to the harmonious development of personality.

The aims of physical education are consistent with psycho-pedagogical action and, even before being a set of physical and sporting techniques, require a holistic approach to the person through body language – or rather, through communication via movement – which can, and must, become a mediator and a means of connecting with other forms of expression (Ambel, 2006).

In various contexts – family, school and society – physical education (Pignato et al., 2016) is still perceived as the recreational discipline par excellence. This

underestimates its role in fostering social cohesion and relationships, its capacity to contribute to personal growth, and its ability to appropriately stimulate the cognitive (Salvini, 2000) and metacognitive abilities linked to lifestyles.

In this regard, the role of the Sports Science professional has, over time, undergone structural changes in roles and functions, with the recognition of specialist figures such as the kinesiologist (in Italian, *chinesiologo*): an expert in movement, identified as a dynamic aspect of personality and the common thread running through the field of physical activity.

Motor action is the result of stimuli that are not only perceived but also processed by the individual's entire somatic-psychic unity. It contributes to maintaining bodily function, improving perceived wellbeing and promoting health; it enhances the tone of the musculoskeletal system while preserving bone density; and it helps to prevent osteoporosis and numerous pathological conditions associated with physical inactivity.

A healthier body helps one feel good about oneself and others. Improved self-esteem, better emotional control (with anxiety and nervousness gradually diminishing until they disappear) and greater tolerance of frustration are among the aspects of personality that benefit most from physical activity.

Physical activity (UNESCO, 1978) therefore supports the processes of growth, development and the formation of bodily identity in children, adolescents and adults, as part of a process through which individuals become aware of their own potential and limitations.

## 2. Kinesiologist

The professional role of the kinesiologist, recently recognised in legislation as part of the field of Sports Science, is characterised by flexibility in the services it can provide across a wide range of areas, including prevention, sport, education, adapted activities, organisation and health promotion.

The debate over the professional scope of the kinesiologist has not been resolved by the enactment of Law 86/2019, subsequently implemented by Legislative Decree No. 36/2021 (Gasparini & Danieli, 2025). The statutory recognition of the profession continues to fuel discussion on professional identity, areas of application and interdisciplinary relationships with other professions operating in the fields of health, prevention (AMPA, preventive and adapted physical activity) and human movement.

There is no doubt, however, that the kinesiologist is the expert in human movement who contributes to maintaining and restoring optimal physical wellbeing.

From a contemporary perspective, the kinesiologist (Bertollo et al., 2003) can be defined as a movement professional whose expertise rests on scientific knowledge of biomechanics, physiology and movement didactics, and who is able to design, conduct, supervise and evaluate physical activity programmes (Introna, 2022) aimed at improving health, functionality, quality of life and the adoption of active lifestyles throughout the lifespan.

This approach allows kinesiological intervention to be seen not merely as the technical application of physical exercise, but as a professional practice geared towards creating conditions favourable to health, autonomy, participation and wellbeing, adopted from a multidimensional perspective and in collaboration with other professionals such as the physiotherapist. The physiotherapist works within the healthcare sector and specialises in the repair, care and

rehabilitation of motor functions following events of various aetiologies. Rather than in terms of professional overlap, the relationship between kinesiologist and physiotherapist can be interpreted from an interdisciplinary standpoint, highlighting the complementarity of their expertise within integrated models of prevention, rehabilitation, health promotion and quality of life.

The kinesiologist, who holds a degree in Sports Science (Zambelli & Pegreffi, 2021), is qualified to provide expertise in the management of physical activities of an educational, sporting or recreational nature. This regulatory recognition is the outcome of the historical and educational development of Italian Sports Science, through a process that has included Presidential Decree 162/82, Ministerial Decrees 509/1999 and 270/2004, the Ministerial Decree of 11 November 2011 and Law 86/2019.

Legislative Decree No. 36/2021 established the following designations: the 'basic kinesiologist', following a three-year Bachelor's degree in Sports Science (L-22); the 'kinesiologist for preventive and adapted physical activity', following a Master's degree (LM-67) (Soren, 2023); the 'sports kinesiologist', following a Master's degree (LM-68); and the 'kinesiologist in sports management', following a Master's degree (LM-47). This classification reflects the growing diversification of the social, educational, preventive and sporting needs that characterise the contemporary relationship between movement, health and wellbeing.

Professional practice may be guided by the principles of the FITT model (Frequency, Intensity, Time and Type), recommended by the American College of Sports Medicine (ACSM) to help improve fitness (Bouchard et al., 2012) and health.

The design of training programmes must focus on the requirements of the training stimulus, such as volume and intensity (Paoli et al., 2013), and on

recovery times, as well as on monitoring physiological response mechanisms and taking care to avoid overtraining (Kreher & Schwartz, 2012). Programmes must reflect the needs, objectives and characteristics of different target groups, including those in preventive and adapted physical activity (D'Intino et al., 2005), through the prescription of Adapted Physical Exercise (APE) (Gao et al., 2023) and the promotion of wellbeing.

The activity can be carried out individually or in groups, in sporting contexts, fitness and wellness centres, preventive and adapted physical activity programmes, and multidisciplinary settings in which movement is increasingly recognised as a strategic resource for prevention, health, the maintenance of functional ability and the improvement of quality of life.

Professional intervention can also support pathways towards the sustainable adoption of active lifestyles, body awareness and people's participation in different areas of life.

**3. Kinesiology**

The primary field of practice of the kinesiologist is kinesiological work (Boccardi & Lissoni, 2003), which concerns the relationship between the musculoskeletal system, human movement and bodily functions.

Kinesiology (Pirola & Memo, 2003), through the application of kinesitherapy, aims to study, interpret and support human motor function in its biomechanical, neuromuscular, functional and adaptive aspects, acting on the relationships between bodily structures, movement and function in order to maintain or restore health. The alignment of the spine is fundamental in kinesiology, since it determines whether or not the posture of the entire body is compromised.

In the contemporary context, however, movement cannot be interpreted exclusively as a biomechanical or joint-related phenomenon; it must be understood as an integrated expression of the interaction between biological, neurological, cognitive, relational and environmental systems.

Kinesiology forms part of functional motor re-education, which aims to eliminate any constraints associated with performing an activity, or to restore, strengthen or regulate an impaired activity. This makes it possible to move beyond an approach focused solely on deficit or pathology, emphasising the role of movement in prevention, the maintenance of function, health promotion and quality of life.

Kinesitherapy is also understood as motor education and/or re-education. It can be applied actively and/or passively, taking care not to neglect the individual's psychological dimension, and includes all those techniques that use external forces for rehabilitation, such as passive postural alignment and passive mobilisation (De Marco & Megna, 1997). In rehabilitative and preventive practice, such interventions can help to maintain joint range of motion, prevent stiffness, support motor function and restore movement capacity, in accordance with the person's clinical and functional condition.

Passive mobilisation, which is divided into passive relaxation techniques and forced passive techniques, tends to exclude the patient's voluntary control and muscle contraction.

Active kinesitherapy, by contrast, is based on using the patient's muscular capacity, working on coordination, muscle trophism, strength and endurance, and thereby promoting an improvement in general wellbeing. It involves motor exercises which, suitably adjusted for intensity and for the specific body area, are based on the type of muscle contraction: isotonic and/or isometric. Adjusting the exercise by controlling the intensity, volume, specificity,

frequency and progression of the stimuli is a fundamental element in designing motor interventions aimed at improving functionality, independence and quality of life. The programme comprises free, assisted and resisted exercises and is particularly suitable for managing the after-effects of skeletal injuries associated with restricted movement and alterations to the musculoskeletal lever system.

Kinesitherapy is the practical component of the rehabilitation process, which begins with diagnosis and prognosis and continues with the formulation of a treatment plan aimed at functional recovery. The plan takes into account the individual's objectives, their active participation and the need to foster body awareness and independence, promoting self-awareness, teaching correct posture and enhancing awareness of one's own motor function.

**4. Quality of life and the identification of postural faults**

Over the past century, the shift from empiricism to demonstrable scientific rigour has reinforced the belief that prevention is more effective than cure. Health must therefore be safeguarded, within a framework of Health Education that fosters health awareness and a preventive mindset. This necessarily involves knowledge of the body and of hygiene and health standards, so as to prevent, where possible, the onset of disease.

The concept of health and wellbeing, closely linked to that of quality of life (QoL), is influenced by variables related not only to general societal factors but also to the individual's needs. Quality of life can be interpreted as a multidimensional construct involving physical, psychological, relational, social and environmental aspects (Schalock & Verdugo Alonso, 2006).

Obesity offers an example of how assessments differ (Mazzeo, 2016; Montesano & Mazzeo, 2019). In countries with more advanced economic and

social development it is regarded as pathological, whereas in socio-economically deprived contexts an obese person may be considered to be in excellent health (McKeown, 1976).

Recent studies have also highlighted differing conceptions of health (Alma-Ata Declaration, 1978) across socio-economic classes within the same country. The contemporary conception of health, by contrast, reflects a dynamic and contextual perspective, shaped by the interaction between biological, psychological, social, cultural and economic factors.

Health must be safeguarded both by individuals, who are called upon to adopt healthy lifestyles, and by policies designed to improve the living conditions of the community, with a focus on the health of all. We can therefore speak of health promotion as a dynamic process aimed at supporting people's ability to exercise greater control over the determinants of their own health and wellbeing (WHO, 1986), which makes it important to identify the needs of both the individual and the community.

The recognised importance of ensuring an adequate quality of life has led to the identification of eight core domains (Schalock & Verdugo Alonso, 2006) and to a recommendation for Adapted Physical Activity (APA) (Maietta Latessa & Belli, 2024): physical and sporting activity modified to identify, accommodate and meet the needs of people with specific requirements or particular health conditions throughout their lives.

The growing prevalence of economic prosperity and mechanisation has contributed to the emergence of the phenomenon known as 'hypokinetic disease', a term coined by Kraus and Raab in 1961 (Di Maglie, 2017). A lack of physical activity (Angelucci, 2015), or worse still its complete absence, causes not only overweight and obesity but also reduced functionality, loss of motor

efficiency and musculoskeletal problems related to posture, understood as the overall position of the body or the relationship between its parts in different static or dynamic conditions.

Postural alignment can be interpreted as an expression of the interaction between biomechanical, neuromuscular, psychomotor, proprioceptive and functional components, and is influenced by a multitude of biological, environmental and behavioural factors.

Postural rehabilitation is facilitated by kinesitherapy treatments involving postural exercises, and the techniques include both segmental and whole-body strengthening exercises. In preventive, adapted and rehabilitative exercise programmes, attention to posture, with particular reference to the spine, is especially important for the early identification of functional alterations, temporary paramorphisms (functional postural deviations) and permanent dysmorphisms (structural deformities).

Without going into the clinical and diagnostic details of the various postural conditions, it is worth emphasising that the early recognition of incorrect postures, functional imbalances or alterations in body alignment can contribute to the design of preventive, educational and movement-based interventions that are more closely aligned with the individual's needs.

From this perspective, the work of the movement professional, the kinesiologist, goes beyond the mere biomechanical correction of movement or posture and takes the form of action aimed at maintaining functionality, autonomy, perceived wellbeing and participation in life contexts.

## 5. From the technical professional to the educational wellbeing professional

The growing complexity of contemporary health needs requires us to move beyond interpretations of movement-related professions based exclusively on technical and performance-related skills or on a mechanistic view of physical exercise.

The rise in chronic conditions (Maietta Latessa, 2025), sedentary lifestyles, an ageing population and the growing attention to mental health and quality of life call for approaches that integrate physical, psychological, relational, educational and social dimensions.

The role of the kinesiologist can be understood not only as that of an expert in exercise planning or motor function, but also as that of a professional called upon to help create conditions favourable to health, body awareness and multidimensional wellbeing.

The effectiveness of physical activity programmes (Warburton & Bredin, 2017) does not depend solely on the technical correctness of the prescribed exercises or on adherence to optimal physiological parameters. It is also shaped by the quality of the experience offered, the meanings attributed to movement, individual motivation, environmental conditions and people's ability to integrate active behaviour into their daily lives.

From this perspective, movement can be interpreted as an experience capable of supporting learning, adaptation and personal development, rather than as physical exercise alone. Physical activity improves functional abilities, and it can also foster self-awareness, the construction of bodily identity, the development of self-efficacy, emotional regulation, social participation and the adoption of lifestyles geared towards wellbeing.

The literature on health promotion shows that the sustained adoption of healthy behaviours requires interventions that support empowerment,

motivation and the active participation of individuals in managing their own health (WHO, 1986). Within this framework, the movement professional does not act solely as a prescriber of exercises but can take on the role of facilitator of educational processes aimed at developing awareness, personal responsibility and autonomy in the management of motor behaviours.

Particularly useful in this regard is the World Health Organization's International Classification of Functioning, Disability and Health (ICF; WHO, 2001). The ICF interprets human functioning as the result of the dynamic interaction between bodily conditions, activities, participation and contextual factors, offering a theoretical framework that moves beyond interpretations focused exclusively on illness, impairment or biological performance.

Applied to the movement professions, this perspective allows motor activity (Montesano, 2019) to be understood, rather than as a purely biomechanical or performance-based practice, as an experience closely linked to people's ability to participate actively in life contexts, maintain independence, develop meaningful relationships and pursue personal goals.

In this direction, the professional competence of the kinesiologist can be broadened to include the educational, preventive, relational and communicative dimensions needed to support children, adolescents, adults, older people and populations with chronic conditions or specific needs in building sustainable pathways to physical activity and wellbeing.

The promotion of health literacy and physical literacy also takes on particular significance (Maulini, 2026). The ability to understand the value of physical activity, choose healthy practices, interpret one's own bodily needs and develop a more mindful relationship with one's body is now a strategic objective of health promotion and wellbeing education (Nutbeam, 2000; Whitehead, 2010; 2019).

From this perspective, the kinesiologist can be seen as a movement professional able to integrate scientific, preventive, organisational and educational skills within a vision of wellbeing understood not simply as the absence of disease but as a dynamic process of personal development, active adaptation to life contexts and the construction of quality of life.

## 6. Conclusions

The kinesiologist is a graduate in Sports Science, a degree title introduced in Italy in the late 1990s as the successor to the ISEF (Higher Institute of Physical Education). The course of study comprises a first-cycle degree (three years) and a second-cycle degree (Master's).

Recent regulatory developments have clarified and articulated the professional profile of the kinesiologist, raising the visibility of competences in exercise planning, preventive and adapted physical activity, the promotion of active lifestyles and wellbeing management in various settings. These competences, applicable in both public and private contexts, also include physical conditioning and an in-depth knowledge of training techniques, together with the methodologies and techniques best suited to the functional assessment of athletes, with specific attention to health protection and the risks associated with doping (Mazzeo & Santamaria, 2017), and to the design and management of sporting activities for people with disabilities.

This work can be carried out individually, as a freelancer and/or personal trainer, or in an organised multidisciplinary outpatient setting.

The analysis proposed here suggests, however, that the role of the kinesiologist should be interpreted beyond a purely technical and functional reading. Human movement is not merely a tool for improving performance, restoring function or managing risk factors; it can be seen as an experience capable of influencing

body awareness, participation, autonomy, empowerment and quality of life. From this perspective, the movement professional can be regarded not only as an expert in physical exercise but also as a promoter of multidimensional wellbeing and a facilitator of pathways towards the sustainable adoption of active lifestyles.

Strengthening the synergies between the sporting, educational, preventive and healthcare sectors therefore appears necessary, so as to give full value to the specific contribution of movement-related professions in shaping pathways to health and quality of life throughout the lifespan.

**References**


Agosti, V., & Borgogni, A. (2024). La cura pedagogica del corpo: una prospettiva 'lifelong'. *CQIIA Rivista*, *44*, 139-147.

Ambel M. (2006), *Quel che ho capito – Comprensione dei testi, prove di verifica, valutazione*, Carocci, Roma.

Antonovsky A. (1996), *The salutogenic model as a theory to guide health promotion*, *Health Promotion International*, 11(1), 11–18.

Barnosell F. (2000), *La fisiopatologia applicata alla riabilitazione*, Trattato di Medicina fisica e riabilitazione, UTET, Torino.

Basaglia N. (1995), *Promozione della qualità in medicina riabilitativa*, in AA.VV., *Valutazione e qualità dell'assistenza in medicina riabilitativa*, Gnocchi Editore, Napoli.

Bertollo M., Merlo R., Pasqualotto G. (2003), *Fondamenti storico-epistemologici delle scienze del movimento umano e della professione di Chinesiologo*, in *Chinesiologia*.

Boccardi S., Lissoni U. (2003), *Cinesiologia*, S.E.U., Roma.

Bouchard C., Blair S.N., Haskell W.L. (2012), *Physical Activity and Health*, Human Kinetics, New York.

Bull F.C., Al-Ansari S.S., Biddle S., et al. (2020), *World Health Organization 2020 guidelines on physical activity and sedentary behaviour*, *British Journal of Sports Medicine*, 54(24), 1451–1462.

Cereda F. (2016), *Attività fisica e sportiva: tra l'educazione della persona e le necessità per la salute*, *Formazione & Insegnamento*, XIV(3s).

D'Intino G., Oronzo S., Di Marco M. (2005), *L'ordinamento e l'organizzazione delle attività e delle competizioni sportive adattate*, FrancoAngeli, Milano.

De Marco M., Megna G. (1997), *Fondamenti e tecniche per il recupero motorio*, Edises, Napoli.

Dichiarazione di Alma Ata (1978), *Conferenza Internazionale sull'Assistenza Sanitaria Primaria*.

Di Maglie A. (2017), Lo sport per la salute ed il benessere psicofisico in età scolare: dai dati rilevati, alcune riflessioni pedagogiche, Formazione & insegnamento, vol. 15, sup2, 2017, pp. 393-404

Engel G.L. (1977), *The need for a new medical model: A challenge for biomedicine*, *Science*, 196(4286), 129–136.

Fabris F., Magnanini A. (2000), *Educazione alla Salute*, Trevisini, Milano.

Freccero R. (2013), *Storia dell'Educazione Fisica e Sportiva in Italia*, Levrotto & Bella, Torino.

Gasparini L., Danieli R. (2025), *L'evoluzione normativa del chinesiologo: analisi giuridico-tecnica dei problemi e possibile soluzione degli stessi*, *Diritto dello Sport*, 6(1).

Gao W., Lv M., Huang T. (2023), *Effects of different types of exercise on hypertension in middle-aged and older adults: a network meta-analysis*, *Frontiers in Public Health*, 11.

Introna N. (2022), *Il binomio «sport e salute» nella riforma del diritto dello sport: istituzioni, strutture, professionalità e responsabilità*, Università di Trento.

Kreher J.B., Schwartz J.B. (2012), *Overtraining syndrome: a practical guide*, *Sports Health*, 4(2), 128–138.

Maietta Latessa P. (2025), Le scienze motorie e l'esercizio fisico adattato:

come integrare l'attività fisica adattata nella terapia farmacologica, *QUADERNI*

*DI DIRITTO DELLE ATTIVITÀ MOTORIE E SPORTIVE*, *21*, 67-71.

Maietta Latessa P., & Belli G. (2024), LONGEVITY: IL CHINESIOLOGO DELLE ATTIVITÀ MOTORIE PREVENTIVE E ADATTATE COME FIGURA DI RIFERIMENTO NELL'AMBITO DELLE ATTIVITÀ MOTORIE, *DIRITTO DELLO SPORT*, *5*, 104-114.

Mazzeo F. (2016), *Current concept of obesity*, *Sport Science*, 9(2), 42–48.

Mazzeo F., Santamaria S. (2017), Doping in sport and its developments in our age,

Italian Journal of Health Education, Sports and Inclusive Didactics,

Vol. 1, N. 1, DOI: https://doi.org/10.32043/gsd.v0i1.62

McKeown T. (1976), *The Role of Medicine*, The Nuffield Provincial Hospital Trust,

1976, trad. it. (1978), Medicina, sogno e miraggio o nemesi, Sellerio, Palermo

Montesano P. (2019), *Valenza Educativa e Preventiva dell'Educazione Fisica e Sportiva*, *Formazione & Insegnamento*, XVII(3s).

Montesano P., Mazzeo F. (2019), *Sports Activities in Obese Teenagers Improve Social Inclusion and Health*, *Sport Mont*, 17(1), 3–8.

Nutbeam D. (2000), *Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century***,** *Health Promotion International*, 15(3), 259–267.

Paoli A., Neri M., Bianco A. (2013), *Principi di Metodologia del Fitness*, Elika, Cesena.

Peterson L. (2002), *Traumatologia dello Sport. Prevenzione e terapia*, UTET, Torino.

Persson P., Bondke Persson A. (2018), *Light and darkness in circadian rhythms*, *Acta Physiologica*, 222:e13036.

Pignato S., Coppola R., Manzo G. (2016), *Valutazione comparativa di modelli di insegnamento di educazione fisica*, *Formazione & Insegnamento*, XIV(1).

Pippi, R., Di Blasio, A., Haxhi, J., Mazzuca, P., Auletta, P., D'Urso, C., ... & Negri, C. (2024). Survey on diabetologists' interest in prescribing Physical Exercise in clinical

practice [Sondaggio sull'interesse dei diabetologi verso la prescrizione di Esercizio Fisico nella pratica clinica]. *J. AMD*, *27*(1), 22-29.

Pirola V., Memo G. (2003), *Cinesiologia*, Edi Ermes, Milano.

Salvini C. (2000), *L'apprendimento motorio dello sviluppo cognitivo*, Edizioni Napoleone, Roma.

Schalock R., Verdugo Alonso M. (2006), *Manuale di qualità della vita. Modelli e pratiche di intervento*, Vannini, Brescia.

Soren G. (2023), *Un riconoscimento per il chinesiologo delle attività motorie preventive e adattate*, *Quotidiano Sanità*.

Warburton D.E.R., Bredin S.S.D. (2017), *Health benefits of physical activity: A systematic review of current systematic reviews***,** *Current Opinion in Cardiology*, 32(5), 541–556.

Whitehead M. (2010), *Physical Literacy: Throughout the Lifecourse*, Routledge, London.

Whitehead M. (Ed.) (2019), *Physical Literacy Across the World*, Routledge, London.

Whitmore J. (2020), *Coaching. Come coltivare la crescita e il successo delle persone,*

NLP Italy.

World Health Organization (1948), *Constitution of the World Health Organization*. Geneva: WHO.

World Health Organization (1986), *Ottawa Charter for Health Promotion*, Geneva: WHO.

World Health Organization (2001), *International Classification of Functioning, Disability and Health (ICF)*, Geneva: WHO.

World Health Organization (2020), *WHO Guidelines on Physical Activity and Sedentary Behaviour*, Geneva: WHO.

World Health Organization (2021), *Geneva Charter for Well-being*, Geneva: WHO.

Zambelli L., Pegreffi F. (2021), *Il laureato in scienze motorie, professionista della pianificazione del benessere e del rilancio socio-sanitario dopo il Covid-19*, *Sanità Pubblica e Privata*.

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