Special Equestrians
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Occupational/Physical Therapy Evaluation Form

Initial:___ Re-Evaluation___

Name:_______________________________________D.O.B.____________________________________

Date of Evaluation:________________________

Precautions:____

Medical History/Diagnosis:____

Specialists seen in last two years:____

Allergies:____

Current Medications:____

Caregiver goals:____

Favorite Toys:____

Current school/therapies:____

Equipment/Orthotics:____

Other modalities:____

Skin integrity:____

	Active R.O.M.	Strength	Pain	Tone	Comments
RightUE:					
Left UE:					
Neck:					
Trunk:					
Right LE:					
Left:					

	Static	Dynamic	Tolerance	Comments
Sitting Supported:				
Sitting Unsupported:				
Standing Supported:				
Standing Unsupported:				

Functional Mobility:____

Communication (Receptive/Expressive);____

Patient's ability to express pain:____

Sensory:____

Behavioral (Impulsiveness, Motivators, Fears):____

Attention / Following Directions:____

Assesment:____

____

Goals:____

____

Signature:____

Address:____