REV. 2007 YEAR _____

FREDERICK COUNTY 4-H THERAPEUTIC RIDING PROGRAM

Physical/Occupational Therapy Assessment

Patient's Name:_____ Date of Birth_____

Diagnosis: _____

_____

_____

Present involvement in any physical therapy programs? (Time/Week): _____

_____

What is patient's program? (Detailed) _____

_____

_____

_____

_____

What are the therapy goals?_____

_____

_____

_____

_____

Muscle Tone/Movement Assessment

Muscle Tone: Please indicate right or left if different,

Present Level of Function

UE, LE:

Spastic:

Flaccid:

Athetoid:

Normal:

PLEASE COMPLETE BACK OF PAGE

Limitations to ROM: Ambulation/Gait:

Balance: Coordination:

Standing:

Sitting:

Secondary problems which may affect riding:

_____ Subluxing or dislocating hips
_____ Primitive or pathological reflexes
_____ Psychological (IQ if pertinent)
_____ Seizures _____ controlled for the last year?
_____ Auditory _____ Speech _____ Vision
_____ Circulation _____ Osteoporosis _____ Sensory loss
_____ Pain _____ Ataxia or Apraxia _____ Orthopedic limitations
_____ Incontinence _____ Allergies
_____ Other

Please describe the problems:

Precautions/Contraindications:

Suggested Activities/Exercises:

Date:
Signature of Therapist:
Telephone:

Therapist's Name (print):
Address: