BLUE MOUNTAIN THERAPEUTIC RIDING
1150 VALLEY ST
WALLA WALLA, WASHINGTON 99362

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

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: