Hope Springs Equestrian Therapy, Inc.
P. O. Box 156, Chester Springs, PA 19425
(610) 827-0931

PHYSICAL THERAPY EVALUATION

Name of Rider: _____ Evaluation Date: _____

Diagnosis: _____

_____

Surgeries performed (with dates): _____

_____

Other pertinent medical history: _____

_____

Muscle strength Gross: _____
Joint ROM Gross: _____
Specific limitations: _____

Muscle Tone: _____

_____

Balance Sitting: _____ Standing: _____
Coordination Gross Motor: _____ Fine Motor: _____
Reflex activity Developmental: _____ Tendon reflexes: _____
Pain Character: _____ Location: _____
Cause: _____ Relieved by: _____

Sensory impairments: _____

_____

Perceptual problems: _____

_____

Communication difficulties: _____

_____

Skin Condition(s): _____

Functional abilities: Mobility: _____
Transfers: _____
ADL Skills: _____

Plans and Goals: _____

_____

_____

_____

_____

_____

Additional comments: _____

_____

_____

_____

_____

_____

_____

_____

Signature of Physical, Occupational or Speech Therapist

SIGNATURE: _____

PRINTED NAME: _____

DATE SIGNED: _____