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

PHYSICAL THERAPY EVALUATION

Name of Student:______________________________ 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: ______________________________

____
____
____
____
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____
____

Signature of Physical, Occupational or Speech Therapist

SIGNATURE: ______________________________

PRINTED NAME: ______________________________

DATE SIGNED: ______________________________