



Hope Springs Equestrian Therapy, Inc.  
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(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:** \_\_\_\_\_