



PHYSICAL THERAPY FORM

To be completed by physical therapist if rider is being seen by a physical therapist.

Name		DOB	Age *
Parent/Guardian		Home Phone	
Email address:		Cell Phone	
Address / PO Box, City, Zip			
Emergency Contact		Emergency Phone	
Diagnosis		Medication(s)	
Seizures? •Yes •No		Allergies? If so, to what	
Type(s) _____ _____		_____ _____	
Medical Precautions: _____ _____			

* minimum age of 3 1/2

* maximum weight of 200 lbs

JOINT ROM – Please check if functionally limited (indicate left, right or bilateral)

	<i>FLEXION</i>	<i>EXTENSION</i>	<i>ABD/ADD</i>	<i>INT ROT</i>	<i>EXT ROT</i>
UE: Shoulder					
Elbow					
Wrist					
LE: Hip					
Knee					
Ankle					

Other limitations or comments:

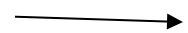
Spinal Alignment (scoliosis, kyhposis): _____

Joint Integrity (hypermobility, dislocations): _____

Muscle Tone: _____ Clonus: _____

Primitive Reflexes Present: • ATNR • STNR • TL • OTHER

Equilibrium & Protective Reactions Impaired? _____



Balance: _____ Sitting: _____ Standing: _____

General Muscle Strength: _____ VE: _____ ME: _____

Functional Grip: _____

Sensory Impairments:

Perceptual Impairments:

Sensory Integration: _____

Motor Planning Problems: _____

Tactile Defensive: _____

Gravitational Insecurity: _____

Communication (verbal, sign, etc): _____

<i>Functional Ability</i>	<i>Independent</i>	<i>Supervision</i>	<i>Minimal Assist</i>	<i>Maximum Assist</i>
Stair Climbing				
Ambulation				
W/C Mobility				
Transfers				
ADL Skills				

<i>Gross Motor Skills</i>	<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Normal</i>
Head Control				
Trunk Control				

Adaptive Equipment:

- AFO'S
- Molded Shoes
- Long Leg Braces
- Thoracic Jacket
- Prosthetics/Orthotics
- Seating Adaptions
- Ambulation Devices

Behavior (attention span, mood swings, cooperation, aggression, etc):

Program Suggestions (to better serve this client):

This form is intended to highlight areas of concern, not as an evaluation form.