



# Cowichan Therapeutic Riding Association

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## PHYSICAL THERAPY EVALUATION

(Please complete this evaluation as fully as possible to enable us to plan a therapy program which will benefit the individual client)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Evaluation Date: \_\_\_\_\_

Surgeries Performed (with dates): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Pertinent Medical History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Muscle Strength: Gross \_\_\_\_\_

Specific Weakness \_\_\_\_\_

Joint ROM: Gross \_\_\_\_\_

Specific Weakness \_\_\_\_\_

Muscle Tone: \_\_\_\_\_

Balance: Sitting \_\_\_\_\_ Standing \_\_\_\_\_

Coordination: Gross Motor \_\_\_\_\_ Fine Motor \_\_\_\_\_

Reflex Activity: Developmental \_\_\_\_\_

Tendon Reflexes \_\_\_\_\_

Pain: Character \_\_\_\_\_ Location \_\_\_\_\_

Caused by \_\_\_\_\_ Relieved by \_\_\_\_\_

Sensory Impairments: \_\_\_\_\_

Perceptual Problems: \_\_\_\_\_

Communications Difficulties \_\_\_\_\_

Skin Condition: \_\_\_\_\_

Functional Abilities: Mobility \_\_\_\_\_

Transfers \_\_\_\_\_

ADL Skills \_\_\_\_\_

Problem List	Plans and Goals
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2.	
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3.	
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4.	
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Additional Comments: \_\_\_\_\_

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\_\_\_\_\_ R.P.T.

\_\_\_\_\_ Address

\_\_\_\_\_ Phone