



THERAPY ASSESSMENT

Name: _____ Date of Birth: _____

Diagnosis: _____

History of therapy interventions: _____

Please describe the following functional abilities:

Sitting balance (head/trunk control, balance reactions, support needed): _____

Standing balance _____

ROM measurements _____

Mobility (with and without assistive devices) _____

Sensory & perception systems _____

Pain _____

Skin conditions _____

Cognitive/Emotional (poor, fair, good)

Follows instructions _____

Frustration tolerance _____

Problem solving _____

Cooperation _____

Attitude _____

Social skills _____

Equipment (when first used, purpose, present use) _____

Communication methods used _____

Present primary therapy goal(s) (short & long term) _____

Precautions and/or contraindications _____

Signature & Title _____ Date: _____

Therapist's Name (please type or print) _____ Phone: _____

School, Center, or Organization: _____ Phone: _____

Address _____ City _____ Zip _____

Please return this form to:

**Sagebrush Equine Training Center
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