



**SunDance Riding Therapy, Inc.  
Physical/Occupational Therapy Evaluation**

**THIS FORM MUST BE COMPLETED ANNUALLY BY ATTENDING  
PHYSICAL OR OCCUPATIONAL THERAPIST**

**Client information:**

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address, City, State and Zip Code \_\_\_\_\_

Disability \_\_\_\_\_

School (if any)  
\_\_\_\_\_

Contact Person \_\_\_\_\_ Telephone \_\_\_\_\_

**Health information:**

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

ROM/JT. Deformities \_\_\_\_\_

Balance/Coordination \_\_\_\_\_

Self-Help Skills \_\_\_\_\_

Mobility \_\_\_\_\_

Assistive Devices \_\_\_\_\_

Posture/Scoliosis \_\_\_\_\_

Associated reactions/abnormal reactions \_\_\_\_\_

(Continued)

Comprehension of verbal instruction \_\_\_\_\_

Speech \_\_\_\_\_

Psychological/behavioral \_\_\_\_\_

Exercises or positions to avoid \_\_\_\_\_

Other special precautions \_\_\_\_\_

Present goals of P.T/O.T. program

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Therapist Authorization:**

Print Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_