Therapeutic Riding Program
Physical/Occupational Therapist Assessment

Please give this form to the PT/OT that the rider is working with on a regular basis. This information is helpful for our instructors.

Client: _____ Age: _____ Date:_____

Disability: _____

Name of PT/OT: _____

PT/OT Contact Information: _____

Please answer the following in terms of goals/objectives etc. that you are striving to achieve with the student.

Short Term Goals:

Long Term Goals:

Other Objectives:

Degree of Coordination:

Area of Strength:

Any precautions: