HORSEPOWER

OCCUPATIONAL THERAPY PRE-RIDING ASSESSMENT

Client's Name: _____ Date of Birth: _____ Age: _____

Pertinent Medical Information:

Contraindications and/or Orthopedic Concerns:

_____

_____

Assistive Devices (Splints, etc., and should they be worn when riding?):

_____

_____

If applicable, please briefly describe the client's current performance and any suggestions for activities to address while at HorsePower:

- Visual Perceptual and Visual Motor Abilities:

_____

- Fine and Gross Motor Abilities (including motor planning):

_____

- Response to Sensory Input (Proprioception, vestibular, tactile, etc.):

_____

- Cognitive Abilities (Sequencing, short and long term memory, safety awareness, impulsiveness, etc.):

_____

Other activities or suggestions that may be beneficial:

_____

This release is valid for the period of (circle one): 1 year 2 years 3 years

Therapist's Signature: _____ Date: _____

Please print, type, or stamp:
Name: _____
Work Mailing Address: _____
Work Phone: (_____) _____-_____ (Optional) Other Phone: (_____) _____-_____

THANK YOU FOR YOUR TIME AND SUGGESTIONS. PLEASE FEEL FREE TO CONTACT US WITH ANY QUESTIONS OR CONCERNS!

HORSEPOWER

PHYSICAL THERAPY PRE-RIDING ASSESSMENT

Client's Name: _____ Date of Birth: _____ Age: _____

Diagnosis: _____

Please indicate if the client has, or has a history of, the following problems by checking yes or no. If **YES**, please include **COMPLETE** information pertaining to the problem.

Problem	**Yes**	**No**	**If Yes, or history of, please describe:**
ROM Limitations	____	____	_____
Recent Surgeries	____	____	_____
Hip Dislocation/Scoliosis	____	____	_____
Behavior Concerns	____	____	_____
Special Equipment	**Yes**	**No**	**Use when riding? (Yes or No)**
Wheelchair	____	____	NA
Braces	____	____	_____
Walker/Crutches	____	____	NA
Eyeglasses	____	____	_____
Hearing Aide	____	____	_____
Other (Please describe)	____	____	_____

Suggested Exercises: _____

_____

Suggested Mounting/Dismounting Procedures: _____

_____

This release is valid for the period of (circle one): 1 year 2 years 3 years

Therapist's Signature _____ **Date** _____

Please print, type, or stamp:
Name: _____
Work Mailing Address: _____

_____
Work Phone: _____ (Optional) Other Phone: _____

THANK YOU FOR YOUR TIME AND SUGGESTIONS. PLEASE FEEL FREE TO CONTACT US WITH ANY QUESTIONS OR CONCERNS!

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