HIGHHOPES
Horses and Humans Improving Lives™

THERAPIST FORM (OT/PT)

Please fill in applicable information that may be incorporated into the riding program. Thank you.

Patient/Participant Name:_____ DOB _____
Diagnosis: _____
Medications: _____
Visual Motor/Perceptual Motor:_____

_____
Sensory Processing (areas of concern/sensitivity): _____

_____
Motor Skills (fine motor, motor planning): _____

_____
Joint Evaluation:_____

_____
Functional Ability & Reflex Limitations:_____

_____
Self-Care: _____

_____
Adaptive Equipment (mobility, discreet trial training, ADL, Augmentative communication, PECS, etc.):

_____

_____
Sitting/ Balance: (include static/dynamic surfaces): _____

_____
Behavior:_____

_____
Safety Awareness:_____

_____
Therapy Goals: _____

_____
Successful Intervention Strategies used (sensory modalities, behavioral, rewards, etc.): _____

_____

Primary Therapist Signature: _____Today's Date: _____

Print Name/Address/Phone: _____

_____

(_____) _____

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