Greystone Manor
Therapeutic Riding Center

Participant's Name_____

Age: _____ Date: _____

THERAPIST ASSESSMENT

Diagnosis: _____

Therapist's Name *(print)*:_____Therapist's Phone Number: _____

School/Agency: _____

Address: _____

Would participant benefit most from individual or small group lesson format? ☐ Individual ☐ Small Group

Does the participant have difficulty with sensory processing? ☐ Yes ☐ No If yes, please describe. _____

_____

_____

_____

_____

Does the participant have deficits in cognition and/or communication? ☐ Yes ☐ No If yes, please describe and suggest adaptations we might use. _____

_____

_____

_____

_____

Physical Evaluation: Describe tone, head control, balance, transfer, and ambulatory status. _____

_____

_____

_____

_____

Suggested Goals: _____

_____

_____

Is there additional information that you would like to share with us? Might include precautions, restrictions, or behavior.

_____

_____

_____

_____

What are the participant's favorite items or rewards? _____

_____

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