Reining Hope Adaptive Equine Assisted Activities & Therapies LLC

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"Wish It, Dream It, Do It!"

THERAPIST FORM (OT/PT/SLT)

Please fill in applicable information that may be incorporated into the riding and/or unmounted program. Thank you!

Name: _____ DOB: _____
Diagnosis: _____
Medications: _____

Visual/Perceptual: _____

Sensory Processing (areas of concern/sensitivity):
_____

Motor Skills (fine/gross 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: _____Date: _____
Print Name, Address, Phone: _____
_____
_____

Please return completed, signed & dated form to: Reining Hope AEAAT, LLC