EQUUSTRONG UK THERAPIST ASSESSMENT

Participant's Name: _____

Date of Report: _____

Diagnosis/Challenge: _____

Age: _____ DOB: _____

Height: _____ Weight: _____

Evaluation: Include assessment of mobility, balance, spatial awareness, motor planning weakness and coordination.

_____
_____
_____
_____
_____
_____
_____

Assistive Devices Used: Wheelchair _____ AFOs _____ Crutches _____

Glasses _____ Hearing Aids _____ Sign Language _____

Communication Board or Picture Icons _____ OTHER _____

Suggested exercises / activities to reinforce present therapies: _____
_____
_____
_____

Hat / Helmet Evaluation: Would this rider benefit from a lightweight hat / helmet in lieu of a normal weight hat / helmet? If yes, please describe reason (i.e. poor head control).
_____
_____
_____
_____

Behaviour or Attitude Challenges and Recommendations: _____
_____
_____
_____

Signed: _____

Job Title: _____