



# Horses of Hope, Inc.

*"Giving Hope One Individual at a Time"*

## OCCUPATIONAL/PHYSICAL THERAPY EVALUATION FORM

Initial: \_\_\_\_\_ Re-Evaluation: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date of Evaluation: \_\_\_\_\_

Precautions: \_\_\_\_\_

Medical History/Diagnosis: \_\_\_\_\_

Specialists seen in last two years: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Caregiver Goals: \_\_\_\_\_

Favorite Toys: \_\_\_\_\_

Current School/Therapies: \_\_\_\_\_

Equipment/Orthotics: \_\_\_\_\_

Other modalities: \_\_\_\_\_

Skin Integrity: \_\_\_\_\_

	Active R.O.M.	Strength	Pain	Tone	Comments
Right UE: _____					
Left UE: _____					
Neck: _____					
Trunk: _____					
Right LE: _____					
Left LE: _____					

	Static	Dynamic	Tolerance	Comments
Sitting Supported: _____				
Sitting Unsupported: _____				
Standing Supported: _____				
Standing Unsupported: _____				

Laurie Flanagan, Executive Director  
19 Forest Drive, Lock Haven, PA 17745  
(570) 295-2904

On-Site Address: 1779 Sulphur Run Road, Jersey Shore, PA 17740  
Email: horsesofhopeinc@gmail.com • Website: www.horsesofhope.org



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## **OCCUPATIONAL/PHYSICAL THERAPY EVALUATION FORM**

Functional Mobility: \_\_\_\_\_

Communication (Receptive/Expressive): \_\_\_\_\_

Patient's ability to express pain: \_\_\_\_\_

Sensory: \_\_\_\_\_

Behavioral (Impulsiveness, Motivators, Fears): \_\_\_\_\_

Attention/Following Directions: \_\_\_\_\_

Assessment: \_\_\_\_\_

Goals: \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

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