simple changes
THERAPEUTIC RIDING CENTER

Mail To:
Simple Changes
PO Box 991
Lorton, VA 22199

Therapist Assessment

Does participant see a therapist (PT,OT, Speech, etc)? ☐ YES ☐ NO
If yes please have therapist fill out form and return

Participant's Name _____ Age _____

Diagnosis _____

School/Employeer_____

Does the Participant have behavior problems? Yes ____ No ____ Please Explain:_____

_____

Suggestions on how the behavior is best dealt with by the instructor:_____

_____

_____

What type of attitude does the Participant have towards him/herself and others? _____

_____

What are your Current Treatment Goals? _____

_____

Does the Participant exhibit any physical weakness? _____

_____

Can you suggest exercises that might help the Participant: _____

_____

Are there any precautions or restrictions the instructor should know about? _____

_____

Circle one: PT OT SLP

Therapist's Name _____ Phone _____

Address: _____City_____St_____Zip_____

Signature _____ **Date** _____