Teacher/Therapist Assessment

Name:_____ Date of Report: _____

Diagnosis/Challenge: _____ Age: _____ DOB: _____

Height: _____ Weight: _____

Evaluate:

Include assessment of mobility, balance, spatial awareness, motor planning weakness, coordination, and development/education level.

_____
_____
_____
_____

Assistive Devices Used:

Wheelchair _____ AFOs _____ Crutches _____ Glasses _____
Hearing Aids _____ Sign Language _____ Communication Board or Picture Icons _____ OTHER _____

***Describe current therapies/activities, IEP and academic goals.

_____
_____
_____
_____

Suggested Exercises/activities to reinforce present therapies: _____

_____

_____

Helmet Evaluation:

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

_____

Precautions/Restrictions: _____
Behavior or Attitude Challenges and Recommendations: _____

_____

Signed: _____ Title: _____

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