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.

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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.

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Suggested Exercises/activities to reinforce present therapies: _________________________

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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). ______________________________________

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Precautions/Restrictions: ____

Behavior or Attitude Challenges and Recommendations: ___________________

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Signed: _______________________________ Title: ___________________________

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