TROT
Therapeutic Riding Of Tri-Cities

Annual Therapist Evaluation

To be completed by participant's primary therapist (circle one): PT OT SLP

If the applicant is NOT receiving PT/OT/SLP services currently, please sign below.

Signature: _____ Date: _____/_____/_____

Name: _____ DOB: ____/_____/_____ Disability: _____

Address:_____ City:_____ State:_____ Zip Code:_____

School:_____ Therapist:_____ Phone: _____

Muscle Tone: _____ ROM/Joint Deformities:_____

Balance Coordination: _____ Self-Help Skills:_____

Mobility:_____ Assistive Devices: _____

Posture/ Scoliosis: _____

Social communication skills: _____

Comprehension of Verbal Instructions:_____ Speech/Discourse:_____

Exercises or position to avoid: _____

Other special precautions:_____

Present Goals of PT/OT/SLP program: _____

Notes:_____

_____

Therapist's Name (please print): _____ Signature: _____

Phone: _____ Date: _____