

**PHYSICAL OR OCCUPATIONAL THERAPY  
EVALUATION**

MIRACLES IN MOTION  
P.O. Box 14  
Cedar Rapids, IA 52406  
857-4141  
miracles@netins.net

The individual, or parents of \_\_\_\_\_ has enrolled in the Miracles in Motion therapeutic horseback riding program. Miracles in Motion strives to extend the physical/occupational therapy goals of this individual into the horsemanship experience.

Your cooperation is essential to the achievements of this rider. Please complete the requested information.

Parent/guardian/client authorization to release information:

Signature \_\_\_\_\_

.....  
Evaluation date \_\_\_\_\_

Diagnosis \_\_\_\_\_ Description \_\_\_\_\_

Surgeries performed (with dates) \_\_\_\_\_  
\_\_\_\_\_

Other pertinent medical history \_\_\_\_\_  
\_\_\_\_\_

Muscle strength: gross \_\_\_\_\_

Specific weakness \_\_\_\_\_

Joint ROM: gross \_\_\_\_\_

Specific limitations \_\_\_\_\_

Muscle tone \_\_\_\_\_

Balance: sitting \_\_\_\_\_ standing \_\_\_\_\_

Coordination: gross motor \_\_\_\_\_ fine motor \_\_\_\_\_

\*\* More on reverse side \*\*

Reflex activity: developmental \_\_\_\_\_

Pain: character \_\_\_\_\_ location \_\_\_\_\_

caused by \_\_\_\_\_ relieved by \_\_\_\_\_

Sensory impairments \_\_\_\_\_

Perceptual problems \_\_\_\_\_

Communication difficulties \_\_\_\_\_

Skin condition \_\_\_\_\_

Functional abilities: mobility \_\_\_\_\_

Transfers \_\_\_\_\_

ADL skills \_\_\_\_\_

Additional comments: \_\_\_\_\_

\_\_\_\_\_



Problem list

Goals/plan

- 1.
- 2.
- 3.
- 4.
- 5.



Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name: \_\_\_\_\_

Daytime phone \_\_\_\_\_

Please return to Miracles in Motion, PO Box 14, Cedar Rapids, IA 52406.