P.O. Box 671828
Chugiak, Alaska 99567
Message Phone & Fax: (907) 929-7876
Email: riders@stridealaska.org

PHYSICAL THERAPY EVALUATION

Rider's Name: ______________________________ Evaluation Date: ____________
Age: ________ Height: ________ Weight: ____________ ☐ Male ☐ Female
Diagnosis: __________________________________ Date of Onset: ____________

Mobility: ☐ Independent Ambulation ☐ Assisted Ambulation ☐ Wheelchair
Braces/Assistive Devices: ____

Muscle Strength/Gross: ____
Specific Weaknesses: ____
Joint ROM/Gross: ____
Specific Limitations: ____
Muscle Tone: ____
Balance: Sitting/Static: ____
Sitting/Dynamic: ____
Standing: ____
Coordination: Gross Motor: ________________ Fine Motor: ________________
Reflex Activity: ____

Pain: ____
Behavioral Problems: ____
Sensory Impairments: ____
Perceptual Problems: ____
Skin Conditions: ____

Functional Abilities: Mobility: ____
Transfers: ____
ADL Skills: ____

Specific Goals of Therapeutic Activities: ______________________________

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Special problems, precautions or contraindications: ______________________________

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Suggested exercises or activities to compliment/reinforce present therapy: ______________

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Additional information or comments: ______________________________

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Therapist Signature: ______________________________

Therapist name (please print): ______________________________

Address: ______________________________

City: ______________________________ State: __________ Zip: __________

Phone: ______________________________

Please return this form to:

P. O. Box 671828
Chugiak, Alaska 99567