

Stepping Stones Therapeutic Riding, Inc.

PHYSICAL OR OCCUPATIONAL THERAPIST AND/OR TEACHER ASSESSMENT

Date: _____

Rider's name: _____

Age: _____

Address: _____

School or group affiliation: _____

Diagnosis: _____

The Stepping Stones Therapeutic Riding, Inc. program is a therapeutic riding program designed to benefit the riders physically, socially, and emotionally. The instructors have been certified through the North American Riding for the Handicapped Association (NARHA). Safety equipment, specially trained horses, and volunteers are used in each program.

In order to ensure the fullest possible protection and greatest personal benefit for each rider, you are asked to furnish the following information, to be used in conjunction with the rider's Physician's Referral, in developing his/her individualized program. All information is maintained in confidentiality as prescribed by Public Laws 94-142.

Physical limitations: _____

Precautions to be observed:

1. Mounting: _____
2. Riding: _____
3. Dismounting: _____

Note: Mounting blocks and ramps are available for use as needed.

Suggested exercises:

1. Pre-ride: _____
2. Mounted: _____
3. Post-ride: _____

Social/emotional responses:

1. Attitude: _____
2. Communication: _____
3. Behavior: _____

Suggested areas to be improved through participation in the Stepping Stones Therapeutic Riding, Inc. program:

Comments:

Signature: _____ Date: _____

Physical Therapist, Occupational Therapist, or Teacher (Circle appropriate one)

Address: _____ Phone: _____

E mail: _____