

**HILLTOP THERAPEUTIC RIDING PROGRAM, INC.**

**THERAPIST FORM (OT/PT)**

**Please fill in applicable information that may be incorporated into the riding program.  
Thank you.**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medications: \_\_\_\_\_

Visual Motor/Perceptual Motor: \_\_\_\_\_

Sensory Processing: (areas of concern/sensitivity) \_\_\_\_\_

Motor Skills: (fine motor, motor planning) \_\_\_\_\_

Joint Evaluation: \_\_\_\_\_

Functional Ability & Reflex Limitations: \_\_\_\_\_

Self-Care: \_\_\_\_\_

Adaptive Equipment (mobility, discreet trial training, ADL, Augmentative communication, PECS, etc.): \_\_\_\_\_

Sitting: balance: (include static/dynamic surfaces): \_\_\_\_\_

Behavior: \_\_\_\_\_

Safety Awareness: \_\_\_\_\_

Therapy Goals: \_\_\_\_\_

Successful Intervention Strategies used: (sensory modalities, behavioral, rewards, etc.)

**Primary Therapist Signature:** \_\_\_\_\_

Print Name/Address/Phone: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Please return completed form to: Hilltop Therapeutic Riding**