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: ____

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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:

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Comments:

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Signature: ____ Date: ______________

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

Address: ____ Phone: ______________

E mail:: ____