Physical or Occupational Therapy Evaluation

Client Name _____

Please complete:

Seizures _____

Medications _____

Reflexes _____

Tone _____

Range of Motion _____

Posture _____

Balance _____

Mobility _____

Gait/Ambulation _____

Senses/Sensation _____

Circulation _____

Development Motor Sequence Activities (where applicable) _____

ADLs _____

Communication _____

Equipment/Aids _____

Additional Notes _____

Precautions _____

Name/Title (please print) _____

Address _____ City _____ State _____ Zip _____

Phone _____ email _____ Organization _____

PT/OT Signature _____ **Date** _____ ***Valid Only if Dated**

Email this form to programs@windrushfarm.org or fax to 888.642.4907