

Client's Name _____

Date _____

THERAPIST ASSESSMENT

Date: _____

Client's Name: _____ Age: _____

Disability: _____ School: _____

Signature of Therapist: _____

Print Therapist's Name: _____

Therapist's Address: _____

Therapist's Phone Number: _____

Suggested Mounting Procedure: (*Circle one*) Ramp Mounting Block

Suggested Lesson Format: (*Circle one*) Group Individual

Sensory Problems: _____

Please provide suggestions on how to encourage the client's communication abilities: _____

Cognitive Abilities/Deficits: _____

Evaluation Summary (Include tone, head control, balance, transfer, and ambulatory status): _____

Treatment Goals: _____

Precautions and/or Restrictions (include any behavior or attitude difficulties and method of treatment): _____

Please use the space below and the back of this form if needed to answer questions in more detail, and also provide any additional information that might help us to work with this client. *Thank you for your time!*