Dear Therapist:

One of your students is interested in adaptive horseback riding lessons here at the EquiCenter. Enclosed you will find an assessment form which will help our PATH certified instructors develop a safe and effective program for him/her. Please fill out the areas that pertain to your expertise and attach any existing assessments or reports that you feel will be helpful to our staff.

Please make special note of any precautions or contraindications to therapeutic equestrian activities.

Adaptive riding is a unique and productive way to improve the quality of life for many children and adults with physical, cognitive or psychological challenges. Your participation in the EquiCenter's programming is welcomed and encouraged. Please feel free to contact us if you would like more information. Thank you in advance for your assistance.

Sincerely,

*Lindsay Alberts*

Director of Equine Operations
EquiCenter, Inc



EquiCenter, Inc. 3247 Rush Mendon Road Honeoye Falls, NY 14472
Phone 585.624.7777 Fax 585.684.7863 info@equicenterny.org

EQUICENTER
WILLIAM & MILDRED LEVINE RANCH

**THERAPY ASSESSMENT**
(Please fill out applicable areas)

Name of client:______________________________ Date of Birth:_____________

History of therapy interventions:______________________________________________
________________________________________________________________________________
________________________________________________________________________________

***Please describe the following functional abilities:***

Sitting Balance (head/trunk control, balance reaction, supports needed):____________________
________________________________________________________________________________

ROM Limitations:________________________________________________________________
________________________________________________________________________________

Mobility (with/without assistive devices):______________________________________________
________________________________________________________________________________

Equipment (when first used, purpose, present use):_______________________________________
________________________________________________________________________________
________________________________________________________________________________

Communication methods used:_____________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Present primary therapy goals:____________________________________________________
________________________________________________________________________________

Precautions and/or contraindications:______________________________________________
__________________________________________________________________________

Signature & Title:_________________________________ Date:_____________
Therapist's name (print):___________________________ Phone:___________
School, Center, Organization:_______________________



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