

PT Assessment Overview

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

School/Boro: \_\_\_\_\_ Program: \_\_\_\_\_ District: \_\_\_\_\_

Name of Therapist: \_\_\_\_\_ Agency: \_\_\_\_\_

Primary Hosp/Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

I. Medical History/Medication/Contraindications/Previous surgery:

II. Reflex Maturation:

III. Range of Motion:-(limitations/contractures)

IV. Muscle Tone/Muscle Strength:

V. Posture and Joint Alignment:

VI. Motor Development:

VII. Wheelchair Management:

VIII. Ambulation:

IX. Sensory Function:

X. Task Behavior:

PT ASSESSMENT SUMMARY

I. Present Level of Function: (include strengths and weaknesses)

II. Therapy Indicated: Frequency \_\_\_\_\_ Duration \_\_\_\_\_ Group \_\_\_\_\_

III. Annual Goals (educationally related)

1.

Short term goals:

- a.
- b.
- c.

Annual Goals

2.

Short term goals:

- a.
- b.
- c.

IV. Explain how therapy will help this student increase function &/or performance in his/her educational program.

V. Recommended adapted equipment

VI. Therapy not indicated: (circle)

- a. Student's disability does not interfere with his/her ability to participate in the educational program.
- b. Student has adequate functional skills and is maintaining expected levels of function.
- c. Student has reached goals and is functioning at maximum level.
- d. Other \_\_\_\_\_

Therapist's Signature \_\_\_\_\_ Date \_\_\_\_\_