LEYDEN AREA SPECIAL EDUCATION COOPERATIVE

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SCHOOL BASED PHYSICAL THERAPY

☐ **INITIAL ASSESSMENT** ☐ **REEVALUATION**

Name **L,F,M):** ______________________________ **School:** ______________________________
Birthdate: ______________________________ **Home School:** ______________________________
Age: ________ **Yrs.** ________ **Mos.** **Therapist:** ______________________________
Teacher: ______________________________ **Date(s):** ____________ ________________
Class: ______________________________

PAST MEDICAL HISTORY/SURGICAL HISTORY:
Diagnosis:

Orthopedic Surgeries:

Bracing/Splinting:

Outside Therapies:

GENERAL OBSERVATIONS:

School Environment: ☐ Single level ☐ Multi level Building (check all that apply)
☐ Ramps ☐Stairs ☐Elevators ☐ Wheelchair Lifts

RANGE OF MOTION AND STRENGTH

Strength is graded numerically from “0” to “5”. “0” is the absence of muscle contraction with “5” being the ability to move through full range of motion against maximal resistance. Range of motion is the available movement in a specific joint and is measured by “degrees”.

MUSCLE TONE

Upper Extremities:	Left	☐ Normal	☐ Spastic	☐ Low
	Right	☐ Normal	☐ Spastic	☐ Low
Lower Extremities:	Left	☐ Normal	☐ Spastic	☐ Low
	Right	☐ Normal	☐ Spastic	☐ Low
Trunk:	Left	☐ Normal	☐ Spastic	☐ Low
	Right	☐ Normal	☐ Spastic	☐ Low

Comments:

SEATING AND FUNCTIONAL POSITIONING

Head Control:	☐ Normal	☐ Good	☐ Fair	☐ Requires External Support
Trunk Control:	☐ Normal	☐ Good	☐ Fair	☐ Requires External Support

Seating System: ☐ Regular Classroom Chair

☐ Modified Seating:

Other Positioning Equipment:

☐ Stander ☐ Feeder Seat ☐ Other:

Additional Comments (include tolerance and amount of adaptation, if applicable):

FUNCTIONAL MOBILITY WITHIN THE SCHOOL ENVIRONMENT

Primary Means of Travel (greater than 50% of the school day):

- ☐ Ambulatory:
  - ☐ Independent
  - ☐ Assisted
    - ☐ Crutches ☐ Cane ☐ Walker:
    - ☐ Other:
- ☐ Non-ambulatory:
  - ☐ Independent
    - ☐ Manual Wheelchair ☐ Other:
    - ☐ Motorized Wheelchair
  - ☐ Assisted
    - ☐ Manual Wheelchair ☐ Other:

Secondary Means of Travel (details, if applicable):

Additional Comments (consider details regarding functional mobility **within the classroom** versus **in between classrooms**, if applicable):

Student Name: Birthdate:

TRANSFERS

Sitting to/from Standing	☐ Independent	☐ Assisted	☐ N/A
Floor to/from Sitting	☐ Independent	☐ Assisted	☐ N/A
Floor to/from Standing	☐ Independent	☐ Assisted	☐ N/A
Toileting	☐ Independent	☐ Assisted	☐ N/A
On/Off transportation vehicles (e.g. car, bus, van)	☐ Independent	☐ Assisted	☐ N/A

Comments:

STAIRS

Ascending

General Sequencing Pattern: ☐ Reciprocal ☐ Step-To ☐ Lateral Stepping ☐ N/A

☐ With Railing

☐ Independent ☐ Assisted

☐ Without Railing

☐ Independent ☐ Assisted

Descending

General Sequencing Pattern: ☐ Reciprocal ☐ Step-To ☐ Lateral Stepping ☐ N/A

☐ With Railing

☐ Independent ☐ Assisted

☐ Without Railing

☐ Independent ☐ Assisted

Comments (consider general safety and managing of school materials during stair climbing):

Student Name: Birthdate:

GENERAL SAFETY

Gait and Movement Analysis:

Endurance:

Balance and Coordination:

Safety Awareness:

SCHOOL BEHAVIOR (check all that apply)

- ☐ Conscientious
- ☐ Follows Directions
- ☐ Good Attention Span
- ☐ Cooperative
- ☐ Unable to Follow Directions
- ☐ Limited Attention Span
- ☐ Uncooperative
- ☐ Unwilling to Follow Directions
- ☐ Impulsive

Comments:

ADDITIONAL INFORMATION

SUMMARY OF EDUCATIONALLY RELEVANT PROBLEMS

SCHOOL BASED THERAPY RECOMMENDATIONS

Physical Therapist

Date