File number..... **- CONFIDENTIAL** **- A.A. .....**

RADIOMARATHON FOUNDATION FOR CHILDREN WITH SPECIAL NEEDS

PHYSIOTHERAPY ***ASSESSMENT*** FORM

Therapist Name: ..... Register number.....

PRIVATE: Address ..... Tel. .....

Date of Evaluation: .....

A. GENERAL INFORMATION OF THE CHILD:

Name:..... Date of birth.:.....

Father's Name: ..... Mother's name: .....

Address:..... Telephone:.....

Referenced by: .....

Doctors / Therapists who monitor the child: .....

.....

Diagnosis:.....

Quadriplegia: **1. Orthopedic problems:**

Diplegia: **2. Psychomotor retardation:**

Hemiplegia: **3. Genetic abnormalities:**

Paraplegia: **4. Other: .....**

B. CHILD'S HISTORY: .....

.....

C. EVALUATION RESULTS/GENERAL COMMENTS .....

.....

.....

PROBLEM LEVEL: Light / Medium / Severe / Very severe

E.OBJECTIVES: .....

.....

Suggested frequency of treatment: .....

Offered frequency of treatment:.....

Reassessment Date: .....

Date:..... **Signature.....**