ST. LUCIE COUNTY SCHOOLS
PHYSICAL THERAPY FUNCTIONAL EVALUATION

INITIAL **3 YEAR** **REEVALUATION**

STUDENT:_____ **DATE OF REPORT:** _____
STUDENT ID:_____ **DOB:** _____
MEDICAID NUMBER:_____ **GRADE:** _____
SCHOOL: _____ **SCHOOL #:** _____
CURRENT ASSIGNMENT:_____ **PHYSICIAN:** _____
DIAGNOSIS CODE: _____ **PARENT(s) :** _____
PRECAUTIONS / MEDS:_____

1 = Functional 2 = Minimal Dysfunction 3 = Moderate Dysfunction
4 = Maximal Dysfunction NA = Not Applicable

I. NEUROMUSCULAR/ MUSCULOSKELETAL (4)

	1	2	3	4	NA
Skeletal deformities					
Range of motion					
Muscle strength					
Transition skills					
Gross motor coordination					

Formalized testing: ❑_____
COMMENTS:

II. SENSORY PROCESSING (6)

	1	2	3	4	NA
Muscle tone					
Joint stability					
Bilateral motor coordination					
Motor planning					

COMMENTS:

III. LEARNING ENVIRONMENT (4)

A. Posture

Posture	1	2	3	4	NA
Sitting					
classroom chair					
w/c					
Standing					
Dynamic standing					
Body mechanics					

COMMENTS:

B. Positioning

	1	2	3	4	NA
Sidelyer					
Prone on wedge					
Supine on wedge					
Prone stander					
Kneeler					
Corner Chair					
Standing Box					
Quadrupled Position					
Advancement Chair					
Rifton Chair					

Other devices: (list)
COMMENTS:

IV. FUNCTIONAL MOBILITY (3)

	1	2	3	4	NA
Equilibrium/ Balance reactions					
Transfers skills					
Ambulation training					
With aids					
Without aids					
Wheelchair training					

❑ Wheelchair Evaluation _____

COMMENTS:

V. EDUCATIONAL ENVIRONMENT (1)

	1	2	3	4	NA
Cafeteria					
Playground					
Bus					
Uneven Terrain/ surface					
Stairs					
Ramps					
Curbs					
Restroom					
Resource class					
Speed					
Endurance					
Energy conservation					

❑ Visual Motor Concerns _____

COMMENTS:

VI. ADAPTIVE PERFORMANCE (2)

	1	2	3	4	NA
Self care					
Physical exercise					
Optimal Positioning for Communication					
Mobility					

COMMENTS:

VII. SUMMARY

Educational Strengths:

- _____
- _____
- _____
- _____
- _____

Educational Concerns:

- _____
- _____
- _____
- _____
- _____

PLAN:

A committee meeting should be held to discuss the results of this evaluation.

Date of Report: _____

Therapist Signature: _____ Date of Signature: _____

cc: Parent/ Adult Student