Adaptive Tricycle Supplemental Information

Child's Name: _____ DOB: _____

Diagnosis: _____ Age: _____

Measurements:

The client's extended leg should reach comfortably from seat to pedal when both feet and torso are strapped into place.

Inseam _____ Height _____ Weight _____

Barriers to Independent Cycling: Please check all that apply and describe

- ☐ Range of Motion
- ☐ Strength
- ☐ Cognition
- ☐ Hearing
- ☐ Seizures
- ☐ Coordination
- ☐ Spasticity
- ☐ Endurance
- ☐ Vision
- ☐ Balance
- ☐ Motivation
- ☐ Other: _____

Describe: _____

_____

_____

_____

Type of Adaptive Bike requested: _____

Maker: _____

Size: _____

Other specifics/components: _____

Form completed by: _____

Name & Title

_____

Contact Information