Rider's Medical History/Physician's Statement for Therapeutic Horseback Riding
Hippotherapy

Participant: ____________________________________ DOB: __________ Height: _______ Wt: _______

Address: ____

Diagnosis: ____ Date of Onset: _____________

Past/Prospective Surgeries: ____

Tetanus Shot: Y N Date vaccinated: _____________

Medications: ____

Seizure Type: ___________________________ Controlled: Y N Date of Last Seizure: ____________

Shunt Present: Y N Date of last revision: _______________________

Special Needs/Precautions: ____

Temperature intolerance: ____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: ____

If Down Syndrome: AtlantoDens Interval X-ray Date: ____________ Result:

Neurologic Symptoms of AtlantoAxial Instability:

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
REFERRAL/PRESCRIPTION			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therpaies. I understand that the PATH Intl center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl center for evaluation and treatment.

Printed Name/Title: ____ MD DO NP PA Other___________

Signature: ____ Date: _______________

Address: ____

Phone: ________________________________ License/UPIN Number: _____________________________

Physician's Statement - Contraindications

Date: ________________________

Patient Name: ____

In order to safely provide equine-assisted services, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic	**Medical/Psychological**
Atlantoaxial Instability - include neurologic symptoms	Allergies
Coxarthrosis	Animal Abuse
Cranial Defects	Cardiac Condition
Heterotopic Ossification/Myositis Ossificans	Physical/Sexual/Emotional Abuse
Joint subluxation/dislocation	Blood Pressure Control
Osteoporosis	Dangerous to Self or Others
Pathologic Fractures	Exacerbations of Medical Conditions (e.g., RA, MS)
Spinal Joint Fusion/Fixation	Fire Settings
Spinal Joint Instability/Abnormalities	Hemophilia
	Medical Instability
Neurologic	Migraines
Hydrocephalus/Shunt	PVD
Seizure	Respiratory Compromise
Spina Bifida/Chiari II Malformation/Tethered Cord/ Hydromyelia	Recent Surgeries
	Substance Abuse
Other	Thought Control Disorders
Age - under 4 years	Weight Control Disorder
Indwelling Catheters/Medical Equipment	
Medications - e.g., Photosensitivity	
Poor Endurance	
Skin Breakdown	

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact the Saddle Light Center at 210-651-9574.