10556 E. Parker Rd, Parker CO 80138 720-851-0927
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PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

******Entire form must be filled out, signed and dated by a physician.**

Client Name:_____ DOB:_____ Ht:_____ Wt: _____
Address:_____ City:_____ Zip Code:_____
Diagnosis:_____ Date of Onset:_____
Past/Prospective Surgeries:_____
Medications:_____
Seizure Type:_____ Controlled? Y N Date of Last Seizure_____
Shunt Present: Y N Date of last revision:_____
Special Precautions/Needs:_____
Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N
Braces/Assistive Devices:_____
For those with Down Syndrome: AtlantoDens Interval X-rays, Date:_____ Result: + --
Neurologic Symptoms of AtlantoAxial Instability:_____

PLEASE INDICATE CURRENT OR PAST DIFFICULTIES IN THE FOLLOWING SYSTEMS/AREAS, INCLUDING SURGERIES:

	YES	NO	COMMENTS
Auditory/auditory processing	____	____	_____
Visual/visual processing	____	____	_____
Tactile Sensation	____	____	_____
Communication	____	____	_____
Heart	____	____	_____
Circulatory	____	____	_____
Skin	____	____	_____
Immunity	____	____	_____
Breathing	____	____	_____
Digestion & Elimination	____	____	_____
Neurologic	____	____	_____
Muscular	____	____	_____
Balance	____	____	_____
Bone Joint	____	____	_____
Allergies	____	____	_____
Learning Disability	____	____	_____
Cognitive	____	____	_____
Emotional / Mental Health	____	____	_____
Behavioral	____	____	_____
Pain	____	____	_____
Other	____	____	_____

PHYSICIAN'S CONFIRMATION

Please note that the following conditions may suggest precautions/contraindications to therapeutic riding. Therefore, when completing the participant's medical history and physician's statement, please note whether these conditions are present and to what degree.

ORTHOPEDIC:

Coxarthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossifications
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities
Atlantoaxial Instability – Include neurologic symptoms

NEUROLOGIC:

Hydrocephalus/Shunt
Spina Bifida
Chiari II malformation
Tethered Cord
Hydromyelia
Seizures
Traumatic Brain Injury

OTHER MEDICAL

Allergies
Indwelling Catheters
Poor Endurance
Skin Breakdown
Blood Pressure Control
Medication- i.e. photosensitivity
Exacerbations of medical conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Weight Control Disorder

PSYCHOLOGICAL:

Animal Abuse
Physical/Sexual/Emotional abuse

Fire Setting
Dangerous to self or others
Substance Abuse
Thought Control Disorders

To my knowledge, based on the above medical information, there is no reason why this person cannot participate in equine assisted activities and/or therapies. I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications.

Physician's Name:_____ **MD DO NP PA Other:**_____
Address: _____ **City:** _____ **Zip:** __
Phone: _____ **License/UPIN Number:** _____
Signature: _____ **Date:** _____