Equine Magic Therapeutic Services

At Horizon Stables
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Apollo, PA. 15613

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PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Please have the following information completed by the client's physician. The physician's signature of consent is required. ***This information is kept confidential***.

Name:_____ Date of Birth:_____ Height:_____ Weight:_____
Address:_____
Diagnosis:_____ Date of onset:_____
Past/Prospective Surgeries:_____
Medications:_____
Shunt present: Y N Date of last revision(s):_____
Date of last Tetanus shot:_____
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:_____ Results: + -
Neurological Symptoms of AtlantoAxial Instability: _____

Please indicate current or past difficulties 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			

	Y	N	Comments
Emotional/psychological			
Pain			
Other			

Precautions: (*Please check all that currently apply to the client and degree of involvement, or note history in space provided. Please note that the following conditions may be contraindicative):*

____Allergies *(specify type*)_____
____Asthma_____
____Atlanto-axial instability_____
____Behaviors_____
____Blood clots, deep vein thrombosis, peripheral vascular disease_____
____Body temperature regulation problems_____
____Bone abnormalities *(osteoporosis, pathologic fractures*)_____
____Contractures/ limited ROM of hips/pelvis_____
____Gastro-intestinal or naso-gastric, tracheal tube_____
____Heart condition / abnormality_____
____Joint/ tendon laxity, subluxation, dislocation_____
____In-dwelling catheter, shunt_____
____Open wounds_____
____Psychiatric condition *(type*)_____
____Respiratory complications *(type*)_____
____Seizures - _____ type _____ Frequency _____ duration_____
____Skin integrity issues, skin breakdown, skin ulcers_____
____Spina Bifida, Chiari II malformation, tethered cord_____
____ Spinal fusion or internal fixators (*specify area, type, and # of vertebrae*):_____
____Traumatic brain injury_____
____Other (*please specify*)_____

To my knowledge there is no reason why this person cannot participate in supervised **equestrian/ hippotherapy activities**. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc…) in the implementation of an effective **equestrian/hippotherapy program.**

Name/Title_____ MD DO NP PA other_____
Signature:_____ Date:_____
Address:_____ City:_____ State:_____ Zip:____
Phone: _____ License/UPIN Number: _____

PLEASE INCLUDE A SCRIPT THAT READS "PT EVALUATION AND TX "