INFORMATION FOR PHYSICIAN

Client's name: _____

Your patient is interested in participating in supervised equestrian assisted activities. In order to determine the appropriateness and safely provide this service, our center requires the completion of this form and the signed physician statement below.

Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

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

Other

Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please contact Hope for the Trail Therapeutic Horsemanship.

325 Brown Creek Rd
Weatherford, TX 76085
www.hopeforthetrail.org
(p) 817-374-4780
(f) 817-374-4781

PHYSICIAN ASSESSMENT & HEALTH HISTORY

~~To be completed by physician~~

Client's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Height: _____ Weight: _____

Date of Last Tetanus shot: _____

Diagnosis:

Primary: _____ Date of Onset: _____

Secondary: _____ Date of Onset: _____

Other: _____ Date of Onset: _____

Past/Prospective Surgeries (include dates and reasons): _____

_____

_____

Medications: _____

_____

Shunts, Implants: _____

Mobility: Independent Ambulation: _____Yes _____No Assisting Devices: _____

_____

As thoroughly as possible, please indicate current or past difficulties/ symptoms in the following systems/ areas that apply including surgeries.

Area	No	Yes	Degree/ Comments
Auditory			
Visual			
Speech			
Tactile/Sensory			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Immunity			
Neurologic			
Muscular			
Orthopedic			
Bowel/Bladder			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Behavior			
Other			

Client's name: _____

Down Syndrome Participants:

An Altlantoaxial x-ray and annual exam to exclude Atlantoaxial instability is required for clients with Down Syndrome over the age of 3. Date of X-Ray:_____ Results:_____

Neurologic Symptoms of Atlantoaxial instability: _____

_____

Seizure Disorder Participants

The following information is required for clients with Seizure Disorders. Would you consider this person's seizures to be:

☐ Completely controlled ☐ Very well controlled ☐ Fairly controlled by medication

Type of seizure: _____

Typical aura: _____

Typical motor activity during seizure: _____

Duration of seizure: _____

Current frequency of seizures: _____

Date of last seizure: _____

Description of client's behavior during post-ictal state: Post-ictal state duration: _____

_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equestrian activities. I understand that Hope for the Trail Therapeutic Riding Center will weigh the medical information indicated above against any existing precautions and/or contraindication before accepting this person for therapeutic horseback riding lessons. Therefore, I refer this person to Hope for the Trail for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD, DO, NP, PA Other _____

Signature:_____ Date:_____

Address:_____

Phone:_____ License/UPIN Number:_____