Pony Power THERAPIES

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Dear Physician:

Your patient, _____ (participant's name) is interested in participating in supervised equestrian activities.

In order to safely provide this service, 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 therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Thank you very much for your assistance, If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the center at the address/phone indicated below.

Orthopedic

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

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

Other

Age- under 4 years
Indwelling Catheters
Medications- i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

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Pony Power THERAPIES

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Participant: _____ DOB: _____ Height: _____ Weight: _____
Street Address: _____ City: _____ State: _____Zip: _____
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: Neurologic 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			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications.

Name/Title: _____ MD DO NP PA
Signature: _____ Date: _____
Street Address: _____ Phone: ( ) _____
City:_____ License/UPIN Number:_____
State:_____
Zip:_____