Healing with Horses Ranch
Therapeutic Riding Center

Date:

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.

Orthopedic		**Medical**		**Psychological**	
Amputation		Allergies		Post Traumatic Stress Disorder	
Cranial Deficits		Blood Pressure Control		Substance Abuse	
Atlanto-axial Instability – neurologic symptoms		Exacerbations of medical conditions		Thought Control Disorders	
Osteoporosis		Heart Conditions		Animal Abuse	
Heterotopic Ossification/Myositis Ossificans		Hemophilia		Physical/Sexual/Emotional Abuse	
Joint subluxation/dislocation		Medical Instability		Fire Settings	
Pathologic Fractures		Migraines		Dangerous to self or others	
Spinal Fusion/Fixation		PVD		**Other**	
Spinal Instability Abnormalities		Respiratory Compromise		Age – under 4 years	
Neurologic		Recent Surgeries		Indwelling Catheters	
Hydrocephalus/Shunt		Medications – i.e., photosensitivity		Weight control Disorder	
Seizure		Skin Breakdown		Poor Endurance	
Stroke					
Spina Bifida: Chiari II malformation Tethered Cord Hydromyelia					

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.

Healing with Horses Ranch
10014 FM 973, Manor, TX 78636
(512)964-0360 office
www.healingwithhorsesranch.org

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Participant's Medical History & Physician's Statement and Prescription

Participant: _____ DOB: _____Height: _____ Weight: _____
Diagnosis: _____ Date of onset: _____
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
***For those with Down Syndrome**:*

Atlanto-Dens Interval x-rays date: _____ Result: + -

Neurologic Symptoms of Atlanto-Axial Instability: _____

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Physician's Prescription

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. I concur with a review of this person's abilities/limitations by a PATH Intl Certified Instructor in the implementations of an effective equestrian program.
Recommended Frequency: 1-2X/week Precautions: _____

Physician's Signature: _____ ***Date***: _____

Physician's Name: _____ Address:

_____

_____

Phone: _____ Fax: _____
E-mail: _____

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