Expires 9/1/2007

GaitWay Therapeutic Horsemanship

RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Rider's Name________________________________ Gender: M F Date of Birth____________ Age _______
Address____________________________City__________________State_____ Zip________ Height________
Parent(s)/Legal Guardian____ Weight________
Primary Diagnosis________________________________ Onset: birth childhood adolescence adulthood
Secondary Diagnosis______________________________ Tertiary Diagnosis______________________________
Medications (prescriptions & over the counter medication—dosage & frequency):

1. ____
2. ____
3. ____

Tetanus Shot: Yes No, Date of shot________; Shunt Present: Yes No, Date of last shunt revision_______
Seizure Type_______________________________________ Controlled: Yes No Date of last seizure________
Mobility:
Ambulatory ___Yes ___No; Wheelchair ___Yes ___No; Crutches ___Yes ___No; Braces ___Yes ___No
Please describe any special precautions needed: ____
____

Before being accepted as a rider, it is essential that the questions are thoroughly and completely answered so that each rider's abilities and limitations are give due consideration by GaitWay's trained instructor(s), the rider's Physician and Therapist. ***PLEASE SEE REVERSE SIDE OF THIS PAGE

Special Precautions ____
____
Specific body movements or positions NOT to be attempted ____
Specific body movements or positions desired ____
***Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If so, please explain.

Areas	Yes	No	Explanation
Auditory			
Visual			Vision w/o correction: Vision corrected to:
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
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 I have provided on the next page against the existing precautions and contraindications.** This form must be signed by attending physician. We cannot accept faxed signature, signature stamp or the signature of any therapist, physician assistant or a nurse practitioner.

Physician's Name (please print)____ Date______________________
Physician's Signature (required) ____________________________________ Date ______________________
Address ____________________________________City ____________________State _____ Zip __________

This form <u>MUST</u> be completed by the Physician in charge.

Rider's name ____

Physician, please note: The following conditions, if present, may represent **<u>precautions or contraindications</u>** to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree. <u>Please be as specific as possible so that we may best serve the rider's needs</u>. Feel free to attach notes in order to best explain the circumstances.

<u>Orthopedic</u>

Atlantoaxial Instability-include neurologist symptoms
Coxa Arthrosis
Cranial Deficits
Hetertopic ossicfication/Myositis Ossificans
Joint Subluxation/Dislocation
Kyphosis
Lordosis
Osteogenisis Imperfecta
Osteoporosis
Pathologic Fractures
Scoliosis (>30º, riding is usually contraindicated)
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

<u>Neurological</u>

Hydrocephalus/Shunt
Paralysis due to Spinal Cord Injury
Seizure
Spina Bifida/Chiari Malformation/Tethered Cord/Hydromyelia
Stroke

<u>Secondary Concerns</u>

Behavior Problems
Age under two years
Age two – four years
Spinal Orthoses
Spinal Stabilization Devices-internal
Acute Exacerbation of Chronic Disorder
Indwelling Catheter/Medical Equipment
Skin Breakdown

<u>Medical/Psychological</u>

Allergies
Animal Abuse
Blood Pressure Control
Cancer
Dangerous to Self and Others
Diabetes
Emotional Abuse
Exacerbations of Medical Conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
Peripheral Vascular Disease
Physical Abuse
Poor Endurance
Respiratory Compromise
Recent Surgeries
Sexual Abuse
Substance Abuse
Thought Control Disorders
Varicose Veins
Weight Control Disorder

Riders with Down Syndrome – Please note: Due to the nature of the activity of horseback riding, no individual with Down Syndrome can be accepted for riding instruction without proof of negative diagnostic x-ray for Atlantoaxial Dislocation Condition.

a) Most recent cervical x-ray for AAI: ____Positive ____Negative Date of X-ray ___________________
b) Annual cervical exam for AAI: ____Positive ____Negative Date of Exam____________________

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please fee free to contact Gaitway Therapeutic Horsemanship at: 225-766-1614.

When <u>both sides</u> of this form are completed, please return it to:

Gaitway Therapeutic Horsemanship
6555 Pikes Lane, Baton Rouge, LA 70808