



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 MUST be completed by the Physician in charge.

Rider's name _____

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

Orthopedic

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

Neurological

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

Secondary Concerns

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

Medical/Psychological

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 feel free to contact Gaitway Therapeutic Horsemanship at: 225-766-1614.

When both sides of this form are completed, please return it to:

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