Physician Assessment Form

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 Healing Hooves.

www.healinghooveslr.org (p) 501-366-8436

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: ____

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: ____
_

Down Syndrome Participants:

An Atlantoaxial 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:

____

____

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

Name/Title:_____________________________________ MD, DO, NP, PA Other _____________________

Signature: ____
Date:_____________________

Address: ____

Phone: ____

License/UPIN Number:_______________________

Down Syndrome Participants:

www.healinghooveslr.org (p) 501-366-8436