Equinox Horse Foundation

Medical History

Client's Name:____________________________________ DOB:_____________ Height:_____________ Weight:____________

Address:____

Diagnosis:____ Date of Onset:_________________

Past/Prospective Surgeries:____

Medications:____

Seizure Types:____ 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: AtlantoDens Interval X-rays, Date:________________________________ Result: + -

Neurological Symptoms of Atlanto Axial Instability: ____

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

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

Given the above diagnosis and medical information, this person in not medically precluded from participation in equine assisted activities and/or therapies. I understand that EHF will weigh the medical information given against the existing precautions and contraindications, Therefore, I refer this person to EHF for ongoing evaluation to determine eligibility for participation.

Name/Title____ MD DO NP PA Other __________

Signature ____ Date: ___________________

Address: ____

Phone: ____________________________________ License/UPIN Number: ______________________________________

Equinox Horse Foundation

Doctor Medical Information for New Client

Date: ________________________

Dear Health Care Provider:

Your Patient, ____
(Participant's Name)

Is interested in participating in supervised therapeutic horseback riding.

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 equine activities. Therefore, when completing this form, please not whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability – include neurological Symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/ Chiari II Malformation/ Tethered Coed/ Hydromyelia

Other
Age – Under 4 Years
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 the patient's participation in equine activities, please feel free to contact the center at the email/phone indicated below.

Sincerely,

Lori Araki , President