HEALING HOOF STEPS

Client Medical History & Physician's Statement 2023

Clients Name:	DOB:	Height:	Weight:
Any Diagnosis:		Date of Onset:	
Medications:			
Special Precautions/Needs:			
Mobility Issues:			

For those with Down syndrome:

Neurologic Symptoms of Atlanto-Axial Instability:	**+**	**-**	***PLEASE CIRCLE ONE***

For those with Scoliosis:

Degree of Scoliosis:

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			

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Potential Precautions and Contraindications for Equine-Assisted Services

Please note *that the following conditions may suggest precautions and/or contraindications to equine-assisted services. Therefore, when completing this form, please note whether these conditions are present and to what degree.*

Orthopedic	NO	YES If so, Please Explain
Amputation		
Atlanto-Axial Instability		
Coxa Arthrosis		
Cranial Deficits		
Heterotopic Ossification/ Myositis Ossificans		
Joint Subluxation/dislocation		
Osteoporosis		
Pathologic Fractures		
Spinal Fusion/Fixation		
Spinal Instability Abnormalities		

Neurologic	NO	YES If so, Please Explain
Hydrocephalus/ Shunt		
Seizures		
Spina Bifida: Chiari II Malformation		
With Tethered Cord		
With Hydromyelia		
OTHER AREA OF CONCERN		

Medical/Psychological	NO	YES If so, Please Explain
Medications: i.e., Photosensitivity/Allergies		
Animal Abuse		
Physical/ Sexual/ Emotional Abuse		
Blood Pressure Control		
Dangerous to self or others		
Heart Conditions		
Hemophilia		
Medical Instability		
Migraines		
Post- Traumatic Stress Disorder		
PVD		
Respiratory Compromise		
Recent Surgeries		
Substance Abuse		
Thought Control Disorder		
Indwelling Catheters		
Poor Endurance		
Skin Breakdown		

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CLIENT'S NAME: _____

Physician's Statement

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 an evaluation and treatment of this person's abilities/limitations by a Certified Therapeutic Riding Instructor in implementing an effective equestrian program.

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

Please print, type, or stamp

Physician's Name: _____
Medical Office/Facility: _____
Address: _____
Email: _____
Phone: _____ Fax: _____