Patient Information Sheet

Today's Date: _____

Child's Name: _____ Date Of Birth: _____

Parent/Guardian Name: _____

Street Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____Text: _____Y or _____N

Email Address:_____

Physician Name:_____

Insurance Company:_____

Insurance ID #:_____

Insured: _____ Self or _____ Parent

If Parent, policy holder's name _____Date of Birth:_____

Therapy: _____ Speech _____ Occupational_____ Physical _____ ABA

Dr. Referral Received: _____ Yes or _____ No

11820 DENTON AVENUE, HUDSON FLORIDA 34667 • PHONE: (727) 862-9101 FAX: (888) 345-5315

PATIENT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

1. Name: _____ Date of Birth:_____
2. Height: _____ Weight: _____
3. Address: _____
4. City : _____ State: _____ Zip Code: _____
5. Diagnosis: _____ 4. Date of Onset: _____
5. Past/Prospective Surgeries: _____
6. Medications: _____
7. Seizure Type: _____ Controlled: _____ Yes _____ No
8. Date of last seizure: _____
9. Shunt present: _____ Yes _____ No Date of last revision(s)_____
10. Date of last Tetanus Shot: _____

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11. Special Precautions/Needs: _____

_____

_____

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12. Mobility: Independent Ambulation: ___Yes ___No Assisted Ambulation: ___Yes ___No

Wheelchair: : ___Yes ___No Braces/Assistive Devices: _____

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13. Please indicate current or past difficulties in the following systems/areas, including surgeries:

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

Other _____

_____

To my knowledge, there is no reason why this person cannot participate in hippotherapy. However, I understand that TherHappy, Inc. will weigh the medical information above against the existing precautions and contraindications. I concur with the review of this person's abilities/limitation by a PT, OT or SLP in the implementation of hippotherapy treatment.

Name/Title _____ MD_____ DO_____ NP _____ PA _____ Other _____
Signature _____ Date: _____
Address: _____ City _____ State _____ Zip Code _____
Phone Number _____ License/UPIN Number _____

THERHAPPY
THERAPY SERVICES, INC.

11820 Denton Ave, Hudson, FL 34667 phone: 727.862.9101 fax: 888.345.5315

PHYSICIAN REQUEST FOR PARTICIPATION IN HIPPOTHERAPY

Dear Physician: Date:

Your Patient, _____, is ____ interested in participating in hippotherapy;

____ interested in continuing to participate in hippotherapy.

In order to safely provide this service, our program requests that you complete/update the attached Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions or contraindications to hippotherapy. 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

Osteoporosis

Pathologic Fractures

Spinal Fusion/Fixation

Spinal Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt

Seizure

Spina Bifida

Tethered Cord

Hydromyelia

Chiari II malformation

Other:

Age-under 2 years

Indwelling Catheter

Medical/Psychological

Allergies

Animal Abuse

Physical/Sexual/Emotional Abuse

Blood Pressure Control

Exacerbations of medical conditions

Fire Settings

Heart Conditions

Hemophilia

Migraines

Peripheral Vascular Disease

Respiratory Compromise

Recent Surgeries

Substance Abuse

Thought Control Disorders

Weight Control Disorder

Poor endurance

Skin breakdown

Medications—i.e. side effects of photosensitivity

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in hippotherapy, please feel free to contact me at the address/telephone number as above.

Sincerely, _____

THERAPY SERVICES, INC.

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PATIENT'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Patient's Name: _____DOB: _____
Phone: home _____ cell: _____
Address: _____City:_____St:_____Zip:_____
Email: Address:_____
Physician's Name: _____
Medical Facility: _____
Health Insurance Co: _____Policy # _____
Allergies to medication: _____
Current medications: _____
_____
In the event of an emergency, contact:

Name: _____Relation: _____Phone: _____
Name: _____Relation: _____Phone: _____
Name: _____Relation: _____ Phone: _____

In the event that an emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, and the above cannot be reached, I authorize **TherHappy** to:

1. Secure and retain medical treatment and transportation if needed
2. Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

CONSENT PLAN

This authorization includes x-rays, surgery, hospitalization, medication and nay treatment procedure deemed 'life saving' by the physician. This provision will only be invoked if the person(s) above is/are unable to be reached.

Consent signature: _____ Date: _____
(Patient, Parent or Legal Guardian, Signed in the presence of **TherHappy** staff)

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event that emergency treatment/aid is required, I wish the following procedures to take place:

Non-consent signature: _____ Date: _____
(Patient, Parent or Legal Guardian, Signed in the presence of **TherHappy** staff)

THERAPY SERVICES, INC.

11820 Denton Ave, Hudson, FL 34667 phone: 727.862.9101 fax: 888.345.5315

CONSENT FOR TREATMENT AND RELEASE OF LIABILITY

All forms must be completed and submitted by the parent/legal guardian prior to participation in hippotherapy. If the patient is of legal age and mentally competent, he/she may complete the forms without parent's or guardian's signature.

Although every effort will be made to avoid accident or injury, NO LIABILITY can be accepted by any of the organizations concerned including ***TherHappy*** , its officers, trustees, agents, employees, each and every one of its members and associates, and the property owners upon whose land the hippotherapy sessions are conducted.

I request and consent to treatment that may include hippotherapy and I have discussed this with my child's doctor. I understand that no liability can be accepted by any of the organizations concerned with this therapy, including ***TherHappy*** and the physician.

Signature: _____ Date: _____

Dated signatures of parent/guardian or patient of legal age must be included.

RELEASE OF LIABILITY

WARNING

UNDER FLORIDA LAW, AN EQUINE ACTIVITY SPONSOR OR EQUINE PROFESSIONAL IS NOT RESPONSIBLE FOR AN INJURY TO OT THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISK OF EQUINE ACTIVITIES.

This release from liability is made and entered into this ____ day of _____, 20____; by and between "Manager" on behalf of "Chad and Andrea Clark" and "TherHappy Therapy Services, Inc., and _____, hereinafter designated "Rider/ Guest" (which shall include Patients, their Parents, and Siblings, Guests, Boarders, and any and all licensees or invitees of TherHappy Therapy Services, Boarders, and any and all licensees or any other individuals who come about upon the property for any other purpose); and _____, parent or guardian of "Rider/ Patient/ Guest" is a minor.

IN CONSIDERATION of being permitted (1) to have access to the stall areas; and/ or (2) to have access to the riding areas of said premises; and/ or (3) to enjoy the use of the riding areas of said premises, either on the undersigned's horse or any boarded on the property; and/ or (4) to be accompanied by guests or to accompany boarders in such areas of the said premises, and/ or to have any training performed upon a horse, Rider, Guest herein duly and freely acknowledges and consents with full knowledge and expressly agrees as follows:

1. Rider/ Guest is responsible for full and complete insurance coverage of all types on his/ her horse, his/ her personal property, and himself/ herself.
2. Rider/ Guest understands that there are inherent risks in and around horses and equine activities and further that horses are often unpredictable and can be dangerous despite any training which a horse might have.
3. The property that you are riding on is predominantly woods and wildlife and the Rider/Guest is responsible for injuries to himself/ herself or property damage as a result of, BUT NOT LIMITED TO, any of the following: Insects, holes made by wildlife, snakes, trees, bushes, poisonous plants, or any other natural element or wild animal.
4. Rider/ guest agrees to assume any and all risks involved in or arising from rider/ guest use of or presence upon manager's property and facilities including without limitation, but not limited to: the risks of death, bodily injury, property damage, falls, kicks, bites, collisions with vehicles, horses or stationary objects, fire or explosion, the unavailability of emergency medical care, and/ or the negligence and/ or deliberate act of another person.
5. Rider/ guest agrees to hold harmless manager and all successors, assign, subsidiaries, franchises, affiliates, officers, directors, employees and agents and specifically I, Andrea Clark and/ or Chad Clark and/ or TherHappy Therapy Services, jointly or severally, and agrees not to make any claim against them or sue them on account of or in connection with any claim, causes of action, injuries, damages, costs or expenses arising out of rider/ guest use of or presence upon manager's property and facilities, including without limitation, those based on death, bodily injury, property damage, including consequential damages.
6. Rider/ Guest agrees to indemnify and defend Manager and all successors, assigns, subsidiaries, franchises, affiliates, officers, directors, employees, and agents specifically I. Andrea Clark and/ or Chad Clark, jointly or severally, against and hold harmless from, any and all claims, causes or actions, judgments, costs or expenses, including attorney's fees, which in any way arise from Rider/ Guest's use of or presence upon the Manager's property and facilities. Rider/ Guest acknowledges receipt of Manager's "Rules and Regulations" and consents to abide by them.

AGREEMENT AND RELEASE FROM LIABILITY CONTRACT

PLEASE READ THIS DOCUMENT CAREFULLY

This AGREEMENT AND RELEASE FROM LIABILITY is entered into on this _____day of_____, in the year _____, by and between Andrea and Chad Clark and TherHappy Therapy Services, Inc. (OWNER) and _____ (RIDER/GUEST), and, if Rider/ Guest is a minor, the parent/guardian of Rider/ Guest_____. In exchange for use of property, facilities, and services of Owner, the Rider/ Guest, his/her heirs, assigns and legal representatives, hereby expressly agree to the following:

1. I agree that horseback riding and all equine activities are inherently dangerous activities AND that these activities will expose me to above normal risks of bodily injury and/or death.

2. I agree that I am responsible for my own safety while engaging in any and all equine activities provided by Andrea Clark and/ or Chad Clark and/ or TherHappy Therapy Services, Inc.

3. I agree to acknowledge all of Owner's rules and regulations pertaining to any and all equine activities occurring with TherHappy Therapy Services and I agree to and am responsible for wearing protective gear appropriate for equine activities to ensure Rider's safety while engaging in such activities.

4. I understand the risks involved in equine activities and **I AGREE TO ASSUME ANY AND ALL RISKS INVOLVED IN RIDER'S USE OF OR PRESENCE UPON OWNER'S PROPERTY AND FACILITIES** while engaging in any equine activity without limitation and including the risks of death, bodily injury, property damage, falls, kicks, bites, unavailability of emergency medical care, and/or the ordinary negligence and/or deliberate act of another person.

5. I agree that Owner, the Owners stable, its agents, and employees are **NOT** liable for any injury to or the death of Rider and/or a participant in equine activities resulting from the inherent risks of equine activities.

6. I agree to hold Owner, Owner's stable, its agents, and employees/ volunteers completely harmless and not liable and release them from all liability whatsoever, including acts of ordinary negligence, associated with any equine activity during Rider's use of or presence upon Owner's property or the adjoining property of others for which permission to ride has been granted.

7. I agree to hold the owner of any and all adjoining property for which permission to ride has been granted completely harmless and not liable and release them from all liability whatsoever, including acts of ordinary negligence, associated with any equine activity during Rider's use of or presence upon the property owner's property.

8. **I AGREE NOT TO SUE** Owner, Owner's stable, its agents and/or employees/ volunteers in association with **ANY** claims, damages, costs, or expenses arising out of Rider's use of or presence upon Owner's property and facilities while engaging in any and all equine activities including those based on death, bodily injury, and property damage, unless the damages are caused by the direct, willful and wanton gross negligence of the Owner.

9. Rider is responsible for complete and full insurance coverage on himself/herself, personal property, and family/ guests present with Rider.

10. Rider and Rider's parent or guardian, (if Rider is a minor) agree that this agreement and release of liability is a contract that when signed by the parties involved will be legally binding to all parties, subject to the above terms and conditions and shall be enforced and interpreted under the laws of the state of Florida.

***** I have read and understand without question, this agreement and release of liability contract before having signed below.

X_____ X_____

Owner's Signature Rider's/ Guest's Signature

X_____ X_____

Owner's Signature Rider's/ Guest's Parent or Guardian's Signature (if Rider is a minor)

THERHAPPY
THERAPY SERVICES, INC.

Cancellation / No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a $25 dollar fee; this will not be covered by your insurance company.

In order to maintain your child's regularly scheduled standing appointment time, please consider this standing appointment time when scheduling other appointments. It is not considered an excused absence if your child must miss their scheduled appointment time at TherHappy Therapy Services for another medical appointment. Please kindly schedule other appointments around your appointments at TherHappy Therapy Services. If a scheduling conflict with another appointment is unavoidable, then kindly give us ample notice to both reschedule your child and fill his / her appointment time with another child who is waiting for an appointment time.

Appointments that are canceled on the same day of service are excused from the $25 missed appointment fee when provided with a doctor's note of excuse.

TherHappy Therapy Services is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (727) 862-9101 or text us at (727) 510-1446 on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday. If prior notification is not given, you will be charged $25 for the missed appointment.

Please sign below to consent to these terms.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Identifying and Family Information:

Child's Name: _____ Sex:____M _____F Birthdate:_____

Father's Name: _____ Daytime Phone:_____

Address: _____ Cell Phone: _____

_____ E-Mail: _____

Mother's Name: _____ Daytime Phone: _____

Address: _____ Cell Phone: _____

E-Mail: _____

Doctor's Name: _____i_____Doctor's Phone: _____

Child Lives With (check one):

___ Birth Parents ___ Foster Parents ___ One Parent

___ Adoptive Parents ___ Parent and Step-Parent ___Other_____

Other Children in the Family:

Name	Age	Sex	Grade	Speech/Hearing Problems

_____N/A_____

_____

_____

_____

Child's Race/Ethnic Group:

___Caucasian, Non-Hispanic ___Hispanic ___African-American

___Na ve American ___Asian or Pacific Islander ___Other_____

Is there a Language other than English spoken in the home? ___Yes ___No

If "yes," which one? _____

Does the child speak the language? ___Yes ___No

Dos the child understand the language? ___Yes ___No

Who speaks this language in your home? _____

Which language does the child prefer to speak in the home? ____English_____

Speech-Language- Hearing

Do you feel that your child has a speech problem? ___Yes ____No

If "yes," please describe: _____

_____

_____ Do you feel that your child has a hearing problem? ___Yes ____No

If "yes," please describe: _____

_____

_____

Has he/she ever had a speech evalua on/screening? ____Yes ___No

If "yes," where and when? _____

What results were you given? _____

_____

Has your child ever had speech therapy? ___Yes ___No

If "yes," where and when? _____

_____

What was he/she working on? _____

Has your child received any other evalua on or therapy (physical, counseling, occupa onal, vision, etc)?

___Yes ___No

If "yes'" please describe:

_____

Is your child aware of, or frustrated by, any speech or language difficulties? _____

_____

What do you see as your child's most difficult problem in the home? _____

_____

What do you see as your child's most difficult problem in school? _____

_____

_____

D evelopmental History

Please tell us the approximate age that your child achieved the following developmental milestones:

_____ sat alone

_____ babbled

_____ put two words together

_____ walked

_____ grasped crayon/pencil

_____ said first words

_____ spoke in short sentences

_____ toilet trained

Does your child…

_____Choke on foods or liquids

_____currently put toys/objects in his/her mouth

_____brush his/her teeth or allow brushing

Current Speech-Language-Hearing

Does your child…

_____ Repeat sounds, words or phrases over and over?

_____ Understand what you are saying to them?

_____Retrieve or point to common objects upon request (ex. ball, cup, shoe)?

_____Follow simple direc ons (ex. "Shut the door." or "Get your shoes.")?

_____Respond correctly to "yes" or "no" ques ons?

_____Respond correctly to who/what / when/ where/ why ques ons?

Your child currently communicates using…

_____body language

_____sounds (vowels, grun ng)

_____words (shoe, doggy, up)

_____2 to 4 word sentences

_____sentences longer than 4 words

_____other _____

Behavioral Characteristics: (Please check all that apply)

____cooperative	___restless
___attentive	___poor eye contact
___willing to try new activities	___easily distracted/short a en on
___plays alone for reasonable length of me	___destruc ve/aggressive
___separation difficulties	___withdrawn
_ _ _easily frustrated/impulsive	___inappropriate behavior
__ _ _ stubborn	___self-abusive behavior

Birth History

Was there anything unusual about the pregnancy or the birth? ___Yes ___No

If "yes," please describe. _____

_____

How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? ____Yes ____No

If "yes," please describe. _____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital? _____

If the child stayed at the hospital, please tell us why and for how long? _____

_____

Medical History

Has your child ever had any of the following? (Please check all that apply)

___ adenoidectomy	___ ear infections (how often?) _____	____ high fevers
___ allergies	___ ear tubes	____ measles
___ breathing difficuties	___ encephalitis	____ meningitis
___ chicken pox	___ flu	____ mumps
___ colds	___ head injury	____ scarlet fever

Medical Continued

___seizures
___tonsillectomy
___tonsillitis
___vision problems
___sinusitis
___sleeping difficul es
___thumb/finger sucking habit

Other serious injury or surgery? _____

Is your child currently (or recently) under a physician's care? ___Yes ___No

If "yes," why? _____

Please list any medica ons that your child takes regularly: _____

_____

School History

If your child is in school, please answer the following:

Name of school and grade in school: _____

Teacher's Name: _____

Has your child ever repeated a grade? _____

What are your child's strengths and/or best subjects? _____

_____

_____

Is your child having difficulty with any subjects? _____

_____

Is your child receiving help in any subject? _____

_____

Additional Comments

_____

_____

_____

_____

_____

_____

_____