



118 Wyman Road
Keene, NH 034631

Riding Season 2010

MEDICAL HISTORY

Date: _____
 NAME: _____ DOB: ___/___/___ AGE: _____
 SEX: _____ HEIGHT: _____ WEIGHT: _____ BP: _____ LAST dT: _____
 DIAGNOSIS: _____
 MEDICATIONS: _____

For diagnosis Trisomy 21, please respond: Atlanto-Axial Subluxation? Yes ___ No ___
 Cervical X-Ray for Atlanto-Axial Subluxation: Positive ___ Negative ___ X-Ray Date: ___/___/___

Please indicate if the client has or had a history of the following secondary problems by checking **YES** or **NO**. If **YES**, please include **COMPLETE** information pertaining to the problem.

PROBLEM	YES	NO	IF YES, OR HISTORY OF, DESCRIBE
AUDITORY IMPAIRMENT	___	___	_____
LEARNING DISABILITY	___	___	_____
COGNITIVE IMPAIRMENT	___	___	_____
PSYCHOLOGICAL IMPAIRMENT	___	___	_____
EMOTIONAL IMPAIRMENT	___	___	_____
SPEECH IMPAIRMENT	___	___	_____
VISUAL IMPAIRMENT	___	___	Glasses: _____
ALLERGIES	___	___	_____
Latex Precautions	___	___	_____
CARDIAC	___	___	_____
CIRCULATORY	___	___	_____
Peripheral Vascular Disease	___	___	_____
Postural Hypotension	___	___	_____
Coagulopathy	___	___	_____
PULMONARY	___	___	_____
Asthma/COPD/BPD/Trach	___	___	_____
NEUROLOGICAL	___	___	_____
Seizures	___	___	_____
Controlled	___	___	Type: _____
Average Frequency	___	___	_____
Hydrocephalus	___	___	_____
Shunt	___	___	_____
Sensory Loss	___	___	_____
Pain	___	___	_____
MUSCULAR	___	___	_____
Contractures	___	___	_____
Neuromotor Impairment	___	___	Type: _____ Distribution: _____
Paralysis/Paresis	___	___	Type: _____ Distribution: _____
Strength/Endurance Impairment	___	___	_____

MEDICAL HISTORY CONTINUED

Name: _____

Date: _____

PROBLEM	YES	NO	IF YES, OR HISTORY OF, DESCRIBE
SKELETAL	_____	_____	_____
Spinal Column	_____	_____	_____
Injury	_____	_____	_____
Defect/Abnormality	_____	_____	_____
Scoliosis/Kyphosis	_____	_____	_____
Degree/Type/Brace	_____	_____	_____
Laminectomy/Fusion	_____	_____	Location: _____ Type: _____
Spondylolisthesis	_____	_____	_____
Joint Disease	_____	_____	_____
Joint Sublux/Dislocation	_____	_____	_____
Fractures	_____	_____	Location: _____ Healed? _____
Heterotopic Ossification	_____	_____	_____
Osteoporosis	_____	_____	_____
Cranial Defects	_____	_____	_____
Other	_____	_____	_____

MEDICAL HISTORY

Please indicate any medical/surgical problems not identified above.

PLEASE INDICATE SPECIAL PRECAUTIONS:

MOBILITY STATUS **YES** **NO** **IF YES, PLEASE DESCRIBE**

AMBULATION			
Independent Walking	_____	_____	_____
Assistive Devices	_____	_____	Type: _____
WHEELCHAIR	_____	_____	Type: _____
Independent Propulsion	_____	_____	_____

OTHER MEDICAL EQUIPMENT (Prosthetics, Orthotics, G-Tube, etc)

Type: _____ Purpose: _____

Type: _____ Purpose: _____

Please describe any other additional information that might help us to work with this patient.

In your opinion, is this patient a reasonable candidate for a Therapeutic Horseback Riding Program? YES ___ NO ___

Please enclose a copy of this rider's most recent physical exam. Thank you for your time.

Physician's Signature: _____ Date: _____

Physician's Name (Please Print): _____

Physician's Address: _____

Telephone Number: _____ - _____ - _____

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