



118 Wyman Road
Keene, NH 034631

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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