Client Medical History & Physicians' Statement (PAGE 1 OF 2)

Participant Name:	Date of Birth:	Sex:	Race:	Height	**Weight:**
Name / Address of Guardian:			Tetanus Shot: YES NO Date:		
Diagnosis:			Date of Onset:		
Medications:					

Please indicate if patient has a problem and/or surgical history in any of the following areas:

AREA	YES	NO	COMMENTS	AREA	YES	NO	COMMENTS
Auditory				Muscular			
Visual				Independent Ambulation			
Spec				Crutches			
Allergies				Braces			
Cardiac				Wheelchair			
Circulatory				Neurological			
Learning Disability				Orthopedic			
Mental Impairment				Pulmonary			
Psychological Impairment				Other			
Seizures		Type:		Controlled:			Date of Last Seizure:
Please complete required information on page 2 for Seizure patients See Page 2 for list of precautions and contraindications							

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR PATIENTS WITH DOWN SYNDROME

If the patient has Down syndrome a full radiological examination establishing the absence of Atlanto-axial Instability is REQUIRED before they may participate in equestrian activities which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine.

Yes	No	
☐	☐	Has an x-ray evaluation for atlanto-axial instability been done? DATE of X-RAY ___________
☐	☐	If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

If this X-Ray is more than 1 year old Please state the result of the most recent visual examination conducted within the past six months:

☐ The client has not had a timely physical examination and so cannot at this point be so certified.

☐ The client's annual physical examination reveals no symptoms of AAI

☐ The client's annual physical examination shows symptoms of AAI. Riding is CONTRAINDICATED.

I have reviewed the attached list of conditions which may present precautions and contraindications to therapeutic horseback riding on page 2, to my knowledge there is no reason why this person cannot participate in supervised equestrian activities:

Physician's Signature:	Date of EXAM:
Physician's Name (please print):	Physician's Phone:

Address:	Physician's FAX:

Client Medical History & Physicians' Statement (PAGE 2 OF 2)

SEIZURE DISORDER PARTICIPANTS
PATH (North American Riding for the Handicapped Association), recommends the following information for PATH Operating Centers for riders with seizure disorders.
Would you consider ____'s seizures to be:

☐ Completely controlled ☐ Very well controlled ☐ Fairly controlled by medication

Type of seizure:	
Typical aura:	
Typical motor activity during seizure:	
Description of client's behavior during post-ictal state:	Post-ictal state duration:
Specific directions as to what to do if a seizure should occur at Pegasus Riding Academy:	
Physician's Signature	Date:

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and, if so, to what degree.

ORTHOPEDIC

Spinal Fusion

Spinal Instabilities/Abnormalities

Alantoaxial Instabilities

Scoliosis

Kyphosis

Lordosis

Hip Subluxation and Dislocation

Osteoporosis

Pathologic Fractures

Coxas Arthrosis

Heterotopic Ossification

Osteogenesis Imperfecta

Cranial Deficits

NEUROLOGIC

Hydorcephalus/shunt

Spina bifida

Tethered Cord

Chiaril Malformation

Hydromyelia

Paralysis due to Spinal Cord Injury

Seizure Disorders

SECONDARY CONCERNS

Behavior Problems

Age under 2 years

Age 2 - 4 years

Acute exacerbation of chronic disorder

MEDICAL/SURGICAL

Allergies

Cancer

Poor Endurance

Recent Surgery

Diabetes

Peripheral Vascular Disease

Varicose Veins

Haemophilia

Hypertension

Serious Heart Condition

Stroke (Cerebrovascular Accident)