



HEARTLAND THERAPEUTIC RIDING, INC.

PO Box 391, Stilwell, Kansas 66085-0391 | info@htrmail.org
T 913-897-3939 | F 913-730-5437 | HeartlandTherapeuticRiding.org

PHYSICIAN'S STATEMENT & MEDICAL HISTORY

MEDICAL EVALUATION

Participant Name _____

DOB _____ Age _____ Height _____ Weight (lbs) _____ Gender: M F

Primary Diagnosis _____ Date of onset _____

Secondary Diagnosis _____ Date of onset _____

Seizures? Y N *Please see page 2 to provide details on seizure activity to help us best serve this participant.*

Mobility? Ambulatory Y N Independent Y N Assisted Y N

Wheelchair? Y N Braces/AFO's? Y N Other Device(s) used _____

For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: Present Absent

Date of last neurologic exam _____

Please indicate current or past special needs in the following systems/areas, including surgeries/procedures. These conditions may suggest precautions and contraindications to equine activities. Please list any Medications taken for each:

Visual _____

Auditory _____

Sensation _____

Communication _____

Heart _____

Breathing _____

Digestion _____

Elimination _____

Circulation _____

Behavioral _____

Musculoskeletal _____

Cognition _____

Allergies _____

Emotional/Mental Health _____

Given the above diagnosis and medical information, **this person is not medically precluded from participation in equine-assisted activities and/or therapies.** I understand that as a PATH Intl. Center, Heartland Therapeutic Riding will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

****For Occupational Therapy--Treatment Orders: Once per week for 52 weeks****

Health Care Provider _____ MD DO NP PA Other

Office Address _____

License/UPIN # _____ Phone _____

Health Care Provider Signature _____ Date _____



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SEIZURE DISCLOSURE

This form must be signed by a health care professional and must be updated annually

Participant's Name _____ Date _____

_____ Participant has no known history of seizures

Seizure Disclosure – physician's signature required if participant has a history of seizures

All participants with a history of any seizures must provide the following information:

Type of seizures _____

Typical aura (pre-seizure sensations or behaviors)

Typical motor activity during seizures

Frequency of seizures (how many seizures per week, month, etc.) _____

Average duration of seizures _____

Any known triggers for seizure activity _____

Any routine medications taken and any side effects (drowsiness or photosensitivity)

Any medications or special procedures to prevent or control seizures on an as needed basis, including nasal spray, suppository, VNS magnets, etc.

Date, type and duration of most recent seizure activity

Date _____ Type _____ Duration _____

I have reviewed the Seizure Disclosure information and to the best of my knowledge the information disclosed above is accurate and complete. I have no concerns about the above named person participating in equine assisted activities and therapies and understand that Heartland Therapeutic Riding has the right to decline services if it is determined that there is a contraindication present at any time in the future.

Physician's Signature _____ Date _____