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 _____

****REQUIRED FOR THOSE WITH DOWN SYNDROME: **** *Neurologic Symptoms of Atlantoaxial Instability (please circle):*

Date of last neurologic exam _____ **Present** **Absent**

MEDICAL HISTORY:

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 diagnoses and medical information, ***this person is not medically precluded from participation in equine-assisted activities and/or therapies including but not limited to horseback riding.*** 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 to evaluate and treat once per week for 12 months****

Health Care Provider _____ **MD DO N 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 _____