HIGH & MIGHTY™
THERAPEUTIC RIDING AND DRIVING CENTER INC.
501 (C)(3)

Date:_____

Dear Health Care Provider:

In order to safely provide Therapeutic Riding, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, **when completing this form**, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability- Include neurologic symptoms
Coxarthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/shunt
Spina Bifida/Chiari II Malformation/Tethered
Seizure

Other

Age- under 4 years
Indwelling Catheter/Medical Equipment
Medications- e.g., photosensitivity
Poor endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure COntrol
Dangerous to Self or Others
Exacerbations of Medical Conditions
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact Laura Corsun at High & Mighty Therapeutic Riding and Driving Center, Inc. at 518-672-4202 / info@high-n-mighty.org

Participant's Medical History & Physician's Statement

Participant:_____DOB:_____Height:_____Weight:_____
Address:_____
Diagnosis:_____Date of Onset:_____
Past/Prospective Surgeries:_____
Medications:_____
Seizure Type:_____Controlled: Y__ N__ Date of last seizure:_____
Shunt Present: Y__ N__ Date of last revision:_____
Special Precautions/Needs_____
_____
Mobility: Independent Ambulation Y__ N__ Assisted Ambulation Y__ N__ Wheelchair Y__ N__
Braces/Assistive Devices:_____
For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: Present___ Absent___
AtlantoDens Interval X-rays, date:_____ Result: +____ -____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

In my opinion, this patient can participate in riding/driving and other equine assisted activities under appropriate supervision. In conjunction with the riding program. I concur in the referral of the patient to the staff physical therapist for evaluation and/or treatment of his abilities and/or limitations in performing exercises and in implementing an effective therapeutic riding program. Should direct physical therapy services be warranted, the following modalities may be included: Neuromuscular re-education, neuromuscular facilitation, therapeutic exercises and activities, gross and fine motor coordination, sensory integrative activities, ADL training and balance training.

Name/Title:_____ MD DO NP PA Other:_____
Signature:_____ Date:_____
Address:_____
Phone:_____ License UPIN Number_____