

MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Today's Date: _____

Client's Name: _____ Address: _____
Date of Birth: _____ Gender: _____ Height _____ Weight _____
Date of last tetanus _____

Name of Disability: _____
Cause: _____ Degree of Involvement: _____
Other Diagnoses: _____
Recent surgical procedures: _____
Brief current medical condition: _____

Current Medications:

Name: _____ Dose: _____ For treatment of: _____
Name: _____ Dose: _____ For treatment of: _____
Name: _____ Dose: _____ For treatment of: _____
Name: _____ Dose: _____ For treatment of: _____

Please check all that apply and specify type:

Use of: Wheelchair _____ Crutches _____ Braces _____
Walker _____ Orthotics/Prostheses, splints, other _____ Can these be removed to
ride? Yes No
Other medical concerns (catheters, shunts, g-tubes, etc)

Please rate the following skills using the scale provided:

- (0) Not able to perform at this time
- (1) Beginning skill that requires moderate assistance from others
- (2) Moderate ability that requires minimal skill from others
- (3) Mastered skill that is performed independently

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|---|---|
| _____ Head and neck control | _____ Unsupported sitting balance |
| _____ Unsupported walking | _____ Unsupported standing balance |
| _____ Upper extremity strength/movement | _____ Lower extremity strength/movement |
| _____ Fine motor strength/movement | _____ Gross motor strength/movement |
| _____ Alertness/Attention | _____ Ability to follow 1-step commands |
| _____ Activity Level/endurance | _____ Ability to follow multi step commands |
| _____ Visual Ability | _____ Expressive Language |
| _____ Socialization skills | _____ Language Comprehension |

Limitation of hip movement: _____
Visual Ability _____
Overall coordination _____
Physical skills needing improvement _____
Sensory skills needing improvement _____
Communication skills needing improvement _____
Educational skills needing improvement _____
Describe any behavior problems _____

Precautions: Please check all that currently apply and degree of involvement or note history in space provided. Please note that the following conditions may be contraindicative or precautions to hippotherapy:

- _____ Allergies _____
- _____ Animal Abuse _____
- _____ Asthma _____
- _____ Atlanto-axial instability (recent X-ray and results) _____
- _____ Behaviors _____
- _____ Blood clots, deep vein thrombosis, peripheral vascular disease _____
- _____ Blood pressure control _____
- _____ Body temperature regulation problems _____
- _____ Bone abnormalities _____
- _____ Contractures/ limited ROM of hips/pelvis _____
- _____ Coxa Arthrosia _____
- _____ Cranial Deficits _____
- _____ Dangerous to self or others _____
- _____ Gastro-intestinal or naso-gastric or tracheal tube _____
- _____ Heart condition/ abnormality _____
- _____ Hemophilia _____
- _____ Heterotopic Ossification/Myositis Ossificans _____
- _____ Hydrocephalus / Shunt _____
- _____ Joint/tendon laxity, subluxation, dislocation _____
- _____ In-dwelling catheter, shunt _____
- _____ Open wounds _____
- _____ Osteoporosis _____
- _____ Peripheral Vascular Disease _____
- _____ Psychiatric condition (type) _____
- _____ Respiratory complications (type) _____
- _____ Seizures (type, frequency, duration) _____
- _____ Skin integrity issues, skin breakdown, skin ulcers _____
- _____ Spina Bifida, Chiari II malformation, tethered cord _____
- _____ Spinal Fusion or internal fixators (specify area, type and # of vertebrae: _____
- _____ Substance Abuse _____
- _____ Traumatic Brain Injury _____
- _____ Other (please specify) _____

PHYSICIAN'S STATEMENT

In my capacity as medical advisor, I consent to the participation of this person in the Palermo Show Stable's Hippotherapy (horseback riding) program. I certify that all of the information that I have given is accurate and represents a complete medical history.

Printed Physician's Name _____

Signature: _____ Date: _____

Stamp or Address: