Positive Strides Therapeutic Riding Center, Inc.

Rider's Medical History and Physician's Statement

Name_____ DOB_____

Address_____

Name of Parent/Guardian/Caregiver_____

Diagnosis(es)_____

_____

Height____ Weight____ Date of Tetanus shot_____

Date of Covid-19 Vaccine 1_____ 2_____ (must present Covid-19 vaccination card)

For persons with Down Syndrome:

____Negative Cervical X-ray for Atlantoaxial instability X-ray date_____

____Negative for clinical symptoms of Atlantoaxial instability

For persons who have seizure disorder

Seizure type_____ Controlled? ____ Date of last seizure_____

Seizure medications_____

Does student use any of the following: Wheelchair____ Crutches____ Braces____

Walker____ Hearing aid____ Cochlear implant____ Other_____

Past surgeries/dates_____

_____

_____

Please indicate if patient has challenges and/or surgeries in any of the following areas

Auditory____ Visual____ Speech____ Cardiac____ Circulatory____ Pulmonary___

Neurological____ Muscular____ Orthopedic____ Allergies____ Learning Disability___

Mental impairment____ Psychological impairment____ Other_____

Please list information regarding all above areas checked_____

_____

_____

_____

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_____

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

ORTHOPEDIC

Spinal fusion____ Spinal instabilities/abnormalities____ Atlantoaxial instabilities____

Scoliosis____ Kyphosis____ Lordosis____ Hip subluxation/dislocation____

Osteoporosis____ Pathologic fractures____ Coxas arthrosis____

Heterotopic ossification____ Osteogenesis imperfecta____ Cranial deficits____

Spinal orthoses____ Internal spinal stabilization devices____

MEDICAL/SURGICAL

Allergies____ Cancer____ Poor endurance____ Recent surgery____ Diabetes____

Peripheral vascular disease____ Varicose veins____ Hemophilia____ Hypertension___

Serious heart condition____ Stroke____

NEUROLOGIC

Hydrocephalus/shunt____ Spina bifida____ Tethered cord____ Chiari II malformation__

Hydromyelia____ Paralysis due to spinal cord injury____ Seizure disorders____

SECONDARY CONCERNS

Behavior challenges____ Age under two years____ Age two to four years____

Acute exacerbation of chronic disorder____ Indwelling catheter____

Please list all medications_____

_____

_____

_____

_____

_____

Drug allergies_____

_____

Physician's printed name_____

Address_____

Phone/email_____

Physician's
signature_____Date_____

Positive Strides Therapeutic Riding Center, Inc.

Physician's Prescription

Prescription for Equine Assisted Activities and Therapies

Client's Name_____

Parent/Guardian's Name_____

Phone/email_____

Precautions_____

_____

_____

Physician'sSignature_____Date_____

Physician's Printed Name_____

Address_____

Phone/email_____

To my knowledge there is no reason why_____cannot participate in supervised equestrian activities. However, I understand that Positive Strides, Inc will weigh the medical information above against the existing precautions and contraindications, which I have described.

Physician's Signature_____Date_____

Physician's Printed Name_____

Address_____

Phone/email_____

Positive Strides Therapeutic Riding Center, Inc.

Physical Therapy Evaluation

Name_____ Date of birth_____

Diagnosis(es)_____

Description_____

_____

Surgeries performed_____Date_____

_____ Date_____

Additional medical/physical therapy history_____

_____

Muscle strength Gross_____

Specific Weakness_____

Joint ROM Gross_____

Specific Weakness_____

Muscle Tone_____

Balance Sitting_____

Standing_____

Coordination Gross Motor_____

Fine Motor_____

Reflex Activity Developmental_____

Tendon Reflexes_____

Pain Character_____Location_____

Caused by_____Relieved by_____

Sensory Impariments_____

Recommendations (as pertains to therapeutic riding)_____

_____

Other Comments_____

_____

Signature_____Date_____

Printed name_____

Address_____

Phone/email_____

_____