Hoofbeats Therapeutic Riding Center, Inc.
At the Virginia Horse Center
P.O. Box 979, Lexington, VA 24450
Ph: 540 464-3337 e-mail: hoofbeats@rockbridge.net
Website: www.hoof-beats.com

Professional Association of Therapeutic Horsemanship International
A Premier Accredited Member Operating Center

TO OUR RIDER: Please note that this *Medical History Form* requires your physician's input and signature. Make sure you allow your physician adequate time to fill out this form and return it to you, so that you can bring it to Hoofbeats before the start of lessons. HOOFBEATS MUST HAVE IN HAND THIS COMPLETED AND SIGNED MEDICAL HISTORY FORM BEFORE YOU WILL BE ABLE TO RIDE.

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT
(To be completed annually by Primary Physician)

Participant's Name:_____ Date of Birth:_____

Address:_____

Height:_____ Weight:_____

Name of Parent/Guardian/Adult Caregiver, if any:_____

Diagnosis:_____ Date of onset:_____

**For persons with Down Syndrome: _ Negative Cervical X-ray for Atlantoaxial Instability X-ray Date:_____

_ Negative for clinical symptoms of Atlantoaxial Instability.

Tetanus Shot ☐ Yes, Date: _____ ☐ No

Seizure Type_____Controlled_____Date of last seizure_____

Medications:_____

_____

Precautions for outdoor activities? (Allergies, sun/heat sensitivity, asthma, etc.)_____ Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory	☐	☐	
Visual	☐	☐	
Speech	☐	☐	
Cardiac	☐	☐	
Circulatory	☐	☐	
Pulmonary	☐	☐	
Neurological	☐	☐	
Muscular	☐	☐	
Orthopedic	☐	☐	
Allergies	☐	☐	
Learning Disabilities	☐	☐	
Mental Impairment	☐	☐	
Psychological Impairment	☐	☐	
Other	☐	☐	

Mobility: Independent Ambulation ☐ Yes ☐ No; Crutches ☐ Yes ☐ No; Braces ☐ Yes ☐ No Wheelchair ☐ Yes ☐ No
Please indicate any special precautions_____

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Participant's
Name:_____

PHYSICIAN'S STATEMENT

To my knowledge there is no reason why this person cannot participate in supervised equestrian and outdoor activities. However, I understand that Hoofbeats Therapeutic Riding Center may contact me to discuss this information and will weigh the medical information above against the existing precautions and contraindications. I concur that a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) may be helpful in the implementing of an effective equestrian program.

Physician Name (Please Print)_____

Physician Signature:_____ Date_____

Address_____City_____State_____Zip_____

Phone: _____

Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore 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 and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurologic
Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Medical/Surgical
Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Secondary Concerns
Behavior Problems
Age under 2 years
Age 2-4 years
Acute exacerbation of chronic disorder
Indwelling catheter

Completeed form may be sent to:
Carol Branscome
Hoofbeats Therapeutic Riding Center
P.O. Box 979
Lexington, VA 24450