Hoofbeats Therapeutic Riding Center, Inc.

P.O. Box 979, Lexington, VA 24450

Dear Therapist, Health Professional, or Educator,

One of your clients/students has applied to receive therapeutic riding instruction at Hoofbeats Therapeutic Riding Center, Inc. this year. Please fill out the attached form to the best of your ability and answer all of those questions which fall within your area of expertise or about which you have some pertinent information. Your input will help us to decide whether this person will benefit from therapeutic riding and/or establish goals for a therapeutic riding plan. If you have any questions about this form, please call our instructors at the Hoofbeats office, 540-464-3337.

Please return the completed forms to the Hoofbeats office, or mail them to Hoofbeats Therapeutic Riding Center, Inc., P.O. Box 979, Lexington, VA 24450.

Information for Therapist

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

Secondary Concerns
Behavior Problems (including a history of violence or abuse toward people or animals or pyromania)
Bipolar disorder
Schizophrenia
Age under 2 years
Age 2-4 years
Acute exacerbation of chronic disorder
Indwelling catheter

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

PARTICIPANT'S MEDICAL HISTORY/ THERAPIST'S STATEMENT
(To be completed by Health or Educational Professional other than M.D.)

Participant's Name:____ Date of Birth:___________________

Address:____

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

Diagnosis:____ Date of onset:________________________

Current Therapy (Last treatment, date, remarks):____

____

Current Medications: ____

____

Please indicate if the client/student 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____

Name of Health/Education Professional:_______________________________________ Specialty/Licensing:____________________

Continued next page

PARTICIPANT'S MEDICAL HISTORY AND THERAPIST'S STATEMENT

Participant's Name:____

Physical Function Assessment(mobility skills, range of motion, etc.)____

____

____

Psycho/Social Function (i.e. emotional/mental health, behavioral issues, support systems, etc.) _____________________________

____

____

Concerns/potential safety issues in a farm or therapeutic riding setting?____

____

____

Therapeutic/Educational Goals? Include goals that might be addressed within the framework of a therapeutic riding lesson:________________

____

____

____

____

THERAPIST'S or EDUCATOR'S STATEMENT

Unless otherwise noted in this form, to my knowledge there is no reason why this person cannot participate in supervised equestrian and outdoor activities. 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.

Therapist Name (Please Print)____

Therapist Signature:___________________________________ Date_______________

Address________________________City__________________ State_____Zip_______

Phone: _________________________ Specialty/Licensing:________________________

State/Federal License Number, if applicable:____